

Wisconsin's Nursing Home Quality Assurance Project

final Report

1978-82



**A demonstration to test
screening and sampling
to assess quality of
care in nursing homes.**

REPORTS
RA
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W6
W6
1982
Final Report

**Wisconsin Department of Health and Social Services
Division of Health · P.O. Box 309 · Madison · WI 53701**

HCFA GRANT NO. 11-P-97029/5

Nursing Home Quality Assurance Project

Demonstration Area 1978 - 1981



- Madison
- Green Bay
- Eau Claire
- La Crosse
- Wisconsin Rapids
- Milwaukee

DISTRICTS

RA
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1982
Final
Report

THE NURSING HOME QUALITY ASSURANCE PROJECT

JULY 1978 THROUGH SEPTEMBER 1982

FINAL REPORT

This report is made pursuant to Grant No. 11-P-97029/5.
The waiver-only demonstration was carried out by staff
in the Bureau of Quality Compliance in the Division of
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CHAPTER I

BACKGROUND AND OVERVIEW

Each state varies in its approach to nursing home regulation. Wisconsin has meshed the state requirement for licensure inspections to determine compliance with state codes with two federal requirements: (1) checking the care of each Medicaid resident and (2) surveying facilities which elect to participate in the Medicare and Medicaid Programs for compliance with federal conditions of participation. The review of residents looks at quality of care and utilization of services. The facility review applies conditions specifying the staff, building safety and administrative requirements that nursing homes must meet to qualify for licensure and certification.

Wisconsin has a history of innovative development in the area of long-term care regulation. The size of the State, scattered distribution of its long-term care facilities, and large number of such facilities combined to force Wisconsin to design and implement cost-effective measures for enforcing state and federal regulations. Nursing home quality assurance is performed by staff in Wisconsin's Department of Health and Social Services. The Department's organization has been streamlined over the years to simplify its operation.

Until 1973, the inspection of care of Medicaid residents and Medicaid reimbursement agency duties were performed by staff in a division separate from the division performing the facility survey. In 1973, the State realized the process could be more efficient if resident inspection and facility survey were performed by the same staff. Although Medicaid reimbursement continued to be handled by a separate division, the related nursing home resident review, licensure and certification survey processes were integrated in one division in the Bureau of Quality Compliance which also regulated other types of health care providers. Thus, the nurses who conducted the Medicaid resident inspections with social workers also worked, along with registered sanitarians and professional engineers or architects, on the Medicare and Medicaid health and life safety survey and the state licensure inspection.

In 1975, Wisconsin went one step further. In an effort to control the ever-increasing burden of paperwork, federal and state codes were combined on one document giving surveyors a master checklist of all applicable codes, thereby reducing the amount of time necessary to record survey findings. This checklist matches equivalent state and federal codes wherever possible, so that violations of equivalent codes are treated as one deficiency for which the facility is asked for one plan of correction.

A. ORIGIN OF PROJECT DEVELOPMENT

In 1976, Wisconsin, through the Medicaid Management Study Team (MMST), took a critical look at its Medicaid Program, particularly at nursing home costs which were the major budget expenditure. The MMST was a task force charged with assessing the processes in place

for monitoring cost and quality of Medicaid long-term care services and recommending ways to make the process more cost-effective. In 1977, Wisconsin paid Medicaid claims of approximately \$270 million to the 452 facilities caring for about 33,000 Medicaid recipients. In 1982, this increased to an estimated \$595.5 million to the State's 446 nursing homes providing care for approximately 37,800 Medicaid recipients. Costs appeared to be generous and continued to increase, but the question of whether the quality of nursing home services was adequate remained unanswered.

Therefore, at the time of the MMST study in 1976, many strengths were already present in Wisconsin's regulatory system which made it superior to other states. First, the facility survey and Medicaid resident inspection were conducted by the same surveyors, allowing for transfer of information between the two processes and greater ability to control nursing home action to correct identified problems. Second, there was a checklist that tied the state process to the federal process. Third, there were professional survey staff, including nurses, social workers, sanitarians, and engineers or architects, who surveyed at approximately the same time in the facilities and functioned, to varying degrees, as a team. Fourth, there was a high degree of interest among the State's legislature and consumer groups, including pending legislation that would strengthen enforcement of state codes. And finally, the quality of care in Wisconsin's homes was felt to be better overall than that in many other states.

The Study Team found, however, that the survey and inspection process required the State to spend the same amount of time in all homes, regardless of quality of care. The Study Team further observed that the State's time in these homes was not efficiently scheduled. Survey staff members could be in and out of a facility during a six to eight week period, in many cases never overlapping to share interdisciplinary findings. Also, the Study Team noted that while facilities may have corrected the problems found, they failed to take corrective action to resolve the source of identified problems. For instance, the facility may have obtained physician signatures on drug orders for current residents, but not set up a process to insure physician review and signature on all future orders.

The Study Team recommended that the State target its time toward the bad homes, that it increase its efficiency by not spending its time unnecessarily in good facilities, and that it obtain expertise in nursing home administration to better identify the source of systems problems by including an advisory nursing home administrator in the survey process.

The Study Team looked at possible approaches to such a survey process, and developed facility screening and resident sampling concepts which could be used to quickly assess whether homes with an average or good history of compliance were still acceptable, or whether further action was needed based on problems which had developed. Although at that time the Study Team did not develop the resident sampling approach beyond a recommendation stage, facility screening was developed to the pilot stage.

The Medicaid Management Study Team convened Wisconsin experts from academia, the State, and the long-term care industry to develop a screening survey tool to evaluate the adequacy of geriatric care and another to evaluate the care of mentally retarded and physically handicapped residents in long-term care facilities. Dimensions were weighted so that review teams would rate the importance of each criterion in the same way. Examples of acceptable and unacceptable performance on each criterion were given. The geriatric instrument was tested by five teams of experts in nine nursing homes. The MMST found that the screening instrument appeared to provide reliable and valid measures of nursing home care. The non-geriatric tool was not tested separately because it resembled the geriatric instrument on almost every criterion. In June 1977, the MMST reports were submitted to the Wisconsin Department of Health and Social Services, the Governor, and the Legislature. The Study Team made several sweeping recommendations for an improved system. In summary the findings were:

- the majority of the State's homes were delivering adequate or better care;
- the State's inspection process made little use of the wealth of information collected during the annual and follow-up visits to carry out enforcement, consultation, or peer organization intervention when a facility was out of compliance;
- the State could not improve the quality of long-term care alone, but a cooperative effort could be successful if it included the nursing home industry, residents' families, consumer groups, and county social service agencies as well as state government;
- screening and sampling a facility--instead of full review--will result in a more cost-effective data collection process and system for allocating resources to the problem nursing homes;
- making information available to those who can act on it (through computerization of routine data collection) is needed and must include both quantitative and qualitative information.

While the MMST recommendations were too wide-ranging to be practically implemented, the Department of Health and Social Services took the basic elements of the proposed improvements under consideration. The Department in redesigning its regulatory process had two major goals: (1) to strengthen its enforcement of nursing home regulations, and (2) to demonstrate in "good" nursing homes a triage or targeted approach to the inspection process.

In October 1977, the Department of Health and Social Services hired two former Study Team members to pursue the development of a screening and sampling approach to surveying nursing homes for

licensure, certification and resident care. Then legislation was passed in November 1977 which increased the State's power to enforce regulations and initiate penalties ranging from forfeitures to closure. At the same time, a department reorganization brought the Medicaid reimbursement agency, the inspection of resident care/survey and certification bureau, and the health planning process under the Division of Health. Also, at this time, social workers, who had always done resident assessments, were included on the nursing home survey team. They began to check for compliance with social services and residents' rights requirements which had previously been done by the nurse. The Department's Division of Health, Bureau of Quality Compliance was then ready to pursue waivers of federal regulations to demonstrate a screening and sampling approach to nursing home inspections.

A proposal was submitted to the federal Health Care Financing Administration (HCFA) under Section 1115 of the Social Security Act and was subsequently approved. Field testing began in May 1978 and continued through June 1982. As a part of the approval, federal requirements mandated an experimental design to enable research and evaluation of project methods. Existing bureau survey staff were used to conduct the demonstration. Additional project staff were hired to implement, administrate and report findings. These staff were funded at 50/50 state and federal match.

B. OVERVIEW OF PROJECT METHODS

The Nursing Home Quality Assurance Project Demonstration (QAP) had, as its primary objective, reallocation of existing resources to improve effectiveness of the State in conducting the facility survey and resident inspection of care. Ultimately, we hypothesized this targeting would result in improved quality of resident care in nursing homes.

The major thrust of the demonstration was to apportion time spent in homes based on the quality of care rather than spending time checking each resident and every regulation. In the facility assessment portion of the project, surveyors could elect to "screen" an average or better facility using ten key quality criteria to verify that necessary care systems were working up to standard. QAP used the same surveyors as the ongoing survey process--a nurse, social worker, sanitarian and engineer--but stressed a multi-disciplinary team approach. The key screening criteria had been identified during the MMST by Wisconsin health care professionals and experts in long-term care. These items focused more directly on quality of care delivery and less on paperwork requirements. In homes with a problem history and in homes where the results of screening suggested a home was currently having problems, surveyors would carry out the mandated full survey using the 1,500 plus code checklist.

Similarly, in the resident assessment portion of the project, surveyors could elect to conduct in-depth reviews of a sample of residents of all pay types. Sampling was designed to be used in homes with a history of delivering adequate or better quality of resident care. It was an alternative to the federally mandated review of all Medicaid residents in a facility. The assumption underlying sampling was that if the system for providing adequate quality of resident care is functioning for a sample of residents, it is functioning for all residents.

QAP used the same professionals who carry out the mandated inspection of care--a nurse and social worker, with a physician when needed. QAP stressed joint assessments of the care of each resident in the sample through staff interviews, resident interviews, and reviews of the resident's medical chart. If surveyors opted to use sampling in a home, the home would then either pass or fail the sample. If the home failed the sample, surveyors would carry out the mandated inspection of care of all Medicaid residents.

Time saved through screening and sampling in average or better homes was to be reallocated to homes with problems. More time could be spent in these homes, and surveyors were encouraged to conduct more varied and innovative follow-up actions in all nursing homes. Surveyors were to consider the most effective means of problem resolution rather than just citing code deficiencies and making recommendations as they traditionally would. They could apply the mandated survey and inspection of care if there were pervasive compliance problems. They could also choose from other actions, such as consultation, inservices, special advisors, surprise surveys, and further investigation, which could be used in addition to or instead of citing code violations.

In addition to the two major components of screening and sampling, QAP tested other innovations in the facility and resident assessment process. It emphasized use of a "strategy session" prior to the survey, an inter-disciplinary team approach to inspection, use of a systems perspective in diagnosing and analyzing problems in a nursing home's performance, and use of an advisory nursing home administrator as a member of the survey team. The latter innovation was particularly controversial because it linked assessment efforts between the State and the nursing home industry. The nursing home administrator served as an advisor to the survey team and provided valuable management and administrative expertise.

Data studies and our subjective assessments in this report address the extent to which the project met its original hypotheses. A glossary (Attachment 1) in the back of this report will help define the terminology used herein.

C. DEMONSTRATION AREAS

The project employed a 2 x 2 factorial experimental design. The two classifications for facility assessment were either the

mandated full survey or QAP screening survey. The two classifications for the resident assessment were either the mandated inspection of care or QAP sampling. This design is diagrammed below.

Figure 1

QAP Experimental Treatment Design

		Resident Assessment	
		Old "Inspection of Care"	"New" Sampling
Facility Assessment	"Old" Full Survey	Old/Old	Old/New
	"New" Screening Survey	New/Old	New/New

This demonstration design gave us four treatment cells: (1) new facility screening and new resident sampling - N/N, (2) new facility screening and old inspection of care - N/O, (3) old full survey and new resident sampling - O/N, and (4) old full survey and old inspection of care - O/O. The O/O cell was essentially the traditional survey and inspection as implemented by the State of Wisconsin, and homes in this treatment cell functioned as a control group.

In 1978, the demonstration began in the rural districts of Eau Claire, La Crosse, and Wisconsin Rapids. Homes from each of the three districts were randomly assigned to the four treatment cells, and assignment was balanced on nine key variables that might affect home performance. These variables included size, ownership, whether the home had a marginal compliance history, percent of mentally retarded/mentally ill residents, an overall quality rating, and licensure type. In each district, the same surveyors were trained in and carried out all four treatment combinations.

In 1979, the project expanded into the urban Milwaukee district. Due to time and staff limitations, only half the homes in the district were included in the project, and these homes were randomly assigned to one of three groups - new/new, old/old, and control - using the balanced home selection process described above. The N/N and O/O homes were our two primary treatment groups, and the same surveyors were trained in and performed both old and new survey methods. Our experience in the rural districts suggested, however, that when the same surveyors were responsible for both methods, it was difficult to maintain a clean separation between methods. Therefore, in the Milwaukee district we added a third group of homes as a control group. These homes received the O/O method and were surveyed by surveyors with no training in QAP methods.

Figure 2

S U R V E Y C O M B I N A T I O N S
I N
D E M O N S T R A T I O N H O M E S

Rural		
Facility Assessment	Resident Assessment	Number
O old	O old	31
O old	N new	33
N new	O old	31
N new	N new	28

Urban		
Facility Assessment	Resident Assessment	Number
O old	O old	20
N new	N new	20

Expansion		
Facility Assessment	Resident Assessment	Number
O old	N new	43
N new	N new	92 *

*Green Bay
is all N/N

Total Homes Receiving N/N Survey Combination = 140
Total Homes Receiving at Least One New Survey Method = 247
Total Homes in State = 453

In 1979 we also randomly selected a subgroup of rural control homes from the Fond du Lac district. These homes are surveyed O/O, and surveyors in the Fond du Lac district had no training in QAP methods. Although we subsequently gathered some monitoring data from these homes, our use of these homes as a comparison group proved to be limited. Observed differences between Fond du Lac control homes and QAP homes were difficult to interpret because of the district effect. Outcomes due to method differences were confounded with outcomes due to district differences.

In anticipation of federal approval for a third year, the project expanded into the Madison and Green Bay districts in April 1980. These districts were the largest districts not already involved in the project, and this expansion was seen as an opportunity to keep the treatment and control groups "pure". All homes in the Green Bay district were assigned to the N/N treatment cell, and this design permitted us to test the N/N method under more ideal circumstances since surveyors were responsible for only one survey method and all homes were potentially eligible to receive the new method. Homes in the Madison district were randomly assigned to two treatment methods - N/N and O/N - using the balanced home selection process. These two treatment cells were selected because they appeared to hold the most potential for eventual statewide use.

Accordingly, as of the beginning of the third project year, the project was operating in a total of six districts - the three rural districts, the urban Milwaukee district, and the two expansion districts; and a total of 247 homes were receiving at least one new survey method. Figure 2 summarizes the survey combinations being applied in the demonstration homes at the beginning of the third project year.

The project established a general guideline that homes would be eligible for screening and sampling for a maximum of three years. At the end of that time period, homes would undergo a full survey and inspection of care. This switch provided an opportunity to validate QAP methods and to gain a more detailed assessment of each home's performance. Thus, by the end of the third project year, individual districts were completing their project involvement. In April 1981, homes in the three rural districts returned to full survey and inspection of care. In March 1982, N/N homes in the Milwaukee district returned to full survey and inspection.

N/N homes in the expansion districts remained in the project until its termination of field operations on June 30, 1982, completing two years in the project. However, O/N homes in the Madison district returned to full survey and inspection of care in October 1981. Although O/N homes had only completed one and a half years in the project, the change was made to provide a within-district comparison group for Madison N/N homes. This change was necessitated by two factors. First, it had become increasingly apparent that comparisons between methods were best made within districts due to observed district differences. Second, QAP staff were focusing

their energies on major method refinements for the fourth project year and needed to reduce the amount of time spent on monitoring field operations.

In May 1982, the project reintroduced resident sampling in the three rural districts of La Crosse, Eau Claire, and Wisconsin Rapids. A full year had elapsed since the districts had completed three years of screening and sampling, and all homes had received a full survey and inspection of care. Effective May 1, 1982, all homes in the districts became eligible for QAP sampling, and this eligibility continued until June 30, 1982, when project field operations terminated.

The decision to reintroduce sampling in the rural districts was initiated upon completion of a study by the Department's Bureau of Evaluation. The study had found differences between QAP and the old method in surveyor assessment of resident care levels. Specifically, the study found that QAP surveyors lowered proportionately more residents rated as skilled care (SNF) to intermediate care levels (ICF) as compared to non-QAP surveyors. However, it was not clear whether this difference was due to sampling or to the QAP in-depth resident review. Therefore to explore these two factors, the Bureau of Evaluation requested that the project test the old method on a sample basis in the rural districts. Surveyors followed QAP fourth year guidelines in drawing the sample and used QAP cut-offs in passing or failing the sample. However, sampled residents were reviewed per guidelines specified under the old method as opposed to QAP in-depth review procedures.

During the project's tenure, the Bureau of Quality Compliance undertook a systematic reorganization of its district structure. These changes affected the homes assigned to participate in QAP. Project staff monitored these changes as they were implemented and where possible made adjustments to minimize the impact on the project.

In June 1981, the Bureau reassigned a total of 68 facilities to a different district. The goals of the reassignment were to reduce travel distances, increase staff productivity, and better balance existing workload. During this process, project staff stayed abreast of the changes. In particular, we kept the independent evaluator, Wisconsin Health Care and Research (WHCRI), informed and gave them an opportunity for input. As a result, WHCRI requested that seven specific nursing homes remain unchanged until July 1982 when the evaluation of QAP would be completed. We were able to comply with this request.

The home switches affected virtually all districts in the State. Some districts only lost homes, some only gained homes; other districts both lost and gained homes. Only one district was unaffected. However, due to the fact that the moves were spread across the State, the number of changes in any single district was moderate.

The two state maps located inside the front and back covers of this report illustrate the district lines during the project's first three years and after the district reorganization at the beginning of the project's fourth year.

Presented below is a pre-post tally of homes in the three QAP districts affected. Tallies are not included for the three rural districts since they had already returned to full survey and inspection of care, nor for Madison O/N homes which returned to full survey and inspection shortly thereafter.

QAP			Original Count	Final Count	# of Original Homes Retained
<u>District and Treatment Cells</u>					
1.	Madison	N/N	41	36	36
2.	Milwaukee	N/N	20	20	20
		O/O	20	19*	19*
3.	Green Bay	N/N	50	59	38

*Change in number not due to district reorganization.

CHAPTER II

EXPERIMENTAL COMPONENTS--EXPLANATION AND ANALYSIS

Methods and procedures tested by the Quality Assurance Project during its four years can be grouped into eight primary components. These components include strategy/core criteria, team approach/scenario, resident sampling, facility screening, use of the advisory nursing home administrator, systems evaluation, surveyor time reallocation, and alternate actions to citing. Each of these components is described in this chapter. Following the description of each component, we present available data studies which address the extent to which we implemented the component and its outcome. The data studies were designed and conducted by QAP staff to monitor implementation of the demonstration methods. In addition, where appropriate, we discuss our subjective assessments of how well the methods worked based on our observations in the field.

WHCRI has researched ten issues concerning project effectiveness. These studies included improvements in quality of care, problem detection, federal and state survey comparisons, level of care, surveyor time allocation, surveyor interventions, problem correction, cost of compliance, and acceptability of methods. Results of these studies are described in the evaluator's final report.

A. STRATEGY/CORE CRITERIA--DESCRIPTION AND IMPLEMENTATION

The beginning of the QAP survey process was not the survey itself but the scheduling and strategy sessions. Supervisors and surveyors in each district held meetings once a month to plan the survey schedule for the upcoming two months, to discuss strategies to be used in each home, and to schedule a critique of the surveys (see Attachment 2). At this meeting, surveyors also scheduled surprise surveys (see Attachment 3), verification visits, complaint investigations and follow-up to previous surveys such as further investigation or consultation. The scheduling/strategy session was considered an important part of the QAP process and strengthened the team approach among surveyors.

The designee for leading the strategy discussion changed over time. Initially, the discussion leader role was rotated among surveyors. At the beginning of expansion into the Madison and Green Bay districts, individual districts were given a choice of rotating the responsibility or routinely assigning it to one person.

The surveyors assigned to the facility were responsible for compiling information on the facilities being scheduled for a survey. Engineers collected their facility information packets from central office and brought them to the strategy session. If the engineer could not attend the session in the district office, a conference call was to be held. The other disciplines reviewed the facility information packets on file within their district office.

Surveyors reviewed and discussed each home's last annual survey, history in setting levels of care, recent changes in key personnel, complaints, and enforcement record. On the basis of this review, surveyors determined which type of facility survey and resident assessment would be most effective in a given home.

In April 1981, QAP administrative staff, with input from QAP surveyors and bureau staff, developed a list of conditions that, when present in a home, may indicate that a full survey and/or inspection of care should be completed in place of screening and sampling. These conditions, called core criteria (see Attachment 4), were developed to encourage greater consistency and appropriateness of survey choice.

When surveyors discussed the home's history, the scheduling coordinator or an assigned surveyor checked the list of core criteria. If the home met one or more criteria, strong consideration was to be given to conducting the full survey and/or inspection of care. If the full survey and/or inspection was not scheduled, the team had to indicate on the scheduling document why that decision was made. The rationale for the decision was reviewed by QAP staff and, when necessary, by discipline supervisors.

In addition to deciding what type of survey was to be done, surveyors established individual areas of responsibility for the survey, set time allowances for the actual survey, and discussed travel distance and plans. The length of the survey was flexible although initial guidelines had been more strict. They were relaxed when surveyors resisted the stricter time allowances.

The final composition of the survey team was also flexible. If surveyors chose to add to the usual complement of team members, they indicated the reason on the scheduling document. For example, when the team decided that a special advisor was necessary, this need was recorded on the form.

QAP always tried to schedule an advisory nursing home administrator for each new facility assessment but occasionally this was not possible. Surveyors, therefore, indicated for which homes the administrator was essential and for which homes less necessary. The team then selected the day on which the advisory administrator should arrive. (See Chapter II, Section E for role of the administrator).

Time for a critique of previous surveys was to be scheduled at the scheduling/strategy meetings. This critique provided a chance for self-evaluation. Surveyors could discuss the survey, review survey forms, or review the tape of the summary conference.

QAP staff attended scheduling meetings and occasionally reinforced strategy procedures when it appeared necessary.

Study Number One: A Summary of Surveyors Use of Option to Switch Survey Methods

Study Intent. Since the decision to match survey methods to the home surveyed was a fundamental part of the QAP process, project staff routinely monitored the frequency with which surveyors switched from screening and/or sampling to the mandated full survey and/or inspection of care. This monitoring was conducted throughout the project for all demonstration districts. The resulting data were useful in helping identify district differences and need for additional surveyor guidelines on the decision to switch methods.

Findings. Table 1 summarizes frequency of surveyor decision to switch to old survey and/or inspection methods in homes eligible for one or more new methods. Data are summarized by district for years 1979 through 1982, and the table reflects the percentage of homes switched. Total number of homes eligible for one or more new methods is shown in parentheses, and this number may vary from year to year depending upon the start-up and end dates of individual districts and treatment cells.

Table 1

Frequency of Surveyor Decision to
Switch from New to Old Survey/Inspection Methods*

Year	District						Total
	1	2	4	5	6	7W	
1979	NA	7%(15)	NA	4%(26)	4%(48)	25%(20)	8%(109)
1980	2%(64)	30%(20)	30%(37)	20%(25)	6%(48)	45%(20)	16%(214)
1981	3%(69)	1%(20)	35%(54)	17%(6)	22%(9)	50%(6)	17%(164)
1/82							
-5/82	14%(14)	25%(4)	43%(23)	NA	NA	NA	32%(41)

*Percentage of homes switched from new to old survey and/or resident inspection of the total number of homes eligible for one or more new methods.

The most notable trend reflected in this data is the degree of variation by district. Districts 4 (Green Bay) and 7W (Wisconsin Rapids) made greatest use of the option to switch from new to old methods, and this use increased over time. In Green Bay, 30%, 35%, and 43% of the homes were switched in 1979, 1980, and 1981 respectively. In contrast, district 1 (Madison) surveyors were least likely to switch methods, ranging from 2% in 1980, 3% in 1981, and 14% in 1982.

There is also a marked variation by year within districts. In district 2 (Milwaukee), 7% of the homes were switched in 1979, 30% in 1980, 1% in 1981, and 25% in 1982. District 5 (La Crosse) shows a similar amount of variation, ranging from 4% in 1979 to 22% in 1981.

Conclusion. Overall, these findings indicate that QAP surveyors do exercise the option to switch from new to old methods. In addition, use of the option, as shown by frequency of switches averaged across all districts, is increasing over time. In 1979, 8% of the homes were switched as compared to 16% in 1980, 17% in 1981, and 32% in 1982.

However, the large amount of variation by district and by year suggests lack of uniformity in making the decision to switch. Each district appears to operate under its own guidelines, and these guidelines may be altered each year.

Study Number Two: Implementation of Core Criteria

Study Intent. QAP has monitored implementation of the core criteria concept since it was initiated in July 1981. We have tallied the number of homes meeting one or more core criteria and then monitored surveyor decisions on how to survey these homes. These data helped us to effectively evaluate use of core criteria.

Findings. Results from the first eleven months of monitoring are shown in Table 2.

Table 2
Implementation of Core Criteria
July 1981 - May 1982

District/ cell	Total homes surveyed	# Homes meeting one or more core criteria	Switched in response to core criteria?:			# Switches due to other reasons	% Switched total
		Full	Partial	None			
Madison District							
N/N	34	10	1	2	7	0	9%
O/N	9	1	-	-	1	0	0%
Milwaukee District							
N/N	14	5	-	3	2	0	22%
Green Bay District							
N/N	53	9	7	1	1	16	45%
Totals	110	25	8	6	11*	16	27%

*Core criteria met:

- (1) Home underwent change in ownership and key staff = 5
- (2) Complaint received and substantiated since last annual survey = 6

The most pronounced finding is a wide district variation in the decision to switch. The percentage of homes switched ranged from zero to 45%. Homes in the Madison district were least likely to be switched even when they met a core criterion. In N/N and O/N homes, 11 of 43 homes met one or more criteria, and there was no change in survey method in 8 of the 11 homes. Two homes were switched to either a full survey or inspection of care, and one home was switched to both full survey and inspection. No other homes were switched for any reasons other than core criteria met.

The Green Bay district made most frequent use of the option to switch, both in response to core criteria and for other reasons. Nine of 53 homes surveyed met one or more criteria, and 8 of the 9 homes were switched. Seven homes received both a full survey and inspection of care, and one home was switched to full survey only. Only one home received the N/N methods as scheduled. In addition, 16 other homes were switched to one or more old methods for reasons other than core criteria. These reasons include history of the home, problems with the nursing home administrator, and homes newly assigned to the Green Bay district.

The Milwaukee district was intermediate in its response to homes which met a core criterion. Three of 10 homes met one or more criteria, and two homes were switched to either full survey or inspection, and one home received a N/N survey as scheduled.

These district differences indicate that the core criteria are not being uniformly applied when surveyors decide on a survey strategy. These differences also suggest that district surveyors may differ in their assessment of the usefulness of core criteria or in their assessment of the appropriateness of using new methods in problem homes. Whatever their source, these differences between districts indicate a need to work toward greater uniformity of practice.

Table 3 summarizes the core criteria met during the period of July 1981 through May 1982.

Table 3

Core Criteria Met in Homes Surveyed
July 1981 - May 1982

Core Criteria	Frequency
Complaints have been received and substantiated since last annual survey.	14
Home has undergone a change in ownership.	11
Home has a poor level of care history.	3
Home received a total of 2 or more Class A or B violations since the last survey.	1
Home will receive its first annual survey.	1
Home is on the Problem Facilities Meeting agenda.	1

Conclusions. In summary we found a wide variation between districts, not only in response to core criteria but in the decision to switch methods for other reasons. Surveyor response ranged from not switching methods in any home even if it met one of the criteria to switching one or more methods in all homes meeting one or more criteria. These findings indicate a clear lack of uniformity in application of the criteria, although the causes of this outcome are not known.

B. TEAM APPROACH/SCENARIO - DESCRIPTION AND IMPLEMENTATION

Team Approach

In implementing the Quality Assurance Project, a team approach to the survey process was emphasized. In the past, surveyors in each discipline did not routinely schedule their visit to a facility on the same days. QAP stressed that surveyors plan and execute the survey as a team. Communication between disciplines began at the scheduling/strategy meeting as surveyors reviewed the home's history. It continued during the survey as team members met frequently and shared information on the home, and it was completed after the survey when the surveyors discussed the home, findings, state actions, and their own performances.

The teams were composed of nurses (RN's), sanitarians (RS's), social workers (SW's), and engineers (PE's). Advisors were called in to assist in areas not covered by the above disciplines. In addition to the above state personnel, the team included a volunteer nursing home administrator who advised the team on management and philosophy problems. The State chose to add the volunteer administrator since it recognized that might gain fresh insight into problems whose source lay in the management or philosophy of the home. Finally, the team could include a physician for the resident inspection of care when needed.

The survey team met for informal conferences as necessary during the survey. QAP methods stressed that individuals function as a team and keep each other informed of observations and findings throughout the survey.

Assessment of Implementation. Overall, surveyors have strictly adhered to scheduling surveys as a team and have only deviated from the team pattern under special circumstances. Although scheduling as a team has almost always been accomplished, some team members have not consistently communicated with each other nor gone beyond their discipline area in assessing the facility. It seems that at times the team approach has been limited to being in the facility at the same time.

Survey Scenario

For the first three years of the demonstration the QAP survey approach utilized two teams over a two to three day period in which the resident and facility assessments were conducted concurrently. The two-team approach and scenario were revised in October 1981, for the fourth year of the demonstration. A five-day scenario that utilized one team (i.e., the same nurse and social worker for both the resident and facility review) was instituted.

Scenario for Years One Through Three (1978-81). On the first day of the survey, the resident and facility assessment team members entered the nursing home together. The person designated as the facility assessment coordinator introduced the teams to the facility staff. The coordinator also explained the new survey process to the facility administrator and gave the administrator a handout explaining the survey methods (see Attachment 5).

The teams then toured the home with the facility administrator. While each individual team member paid attention to areas in his or her discipline, the main function of the tour was to gain a perspective on the home's overall care delivery system and to pinpoint areas which may require closer investigation. Team members were encouraged to share individual observations with the surveyor responsible for particular areas (e.g., the sanitarian would tell the social worker if he or she noted exposure of a resident or any violation of resident rights.) After the tour, the teams divided to carry out the facility and resident assessments.

If the advisory administrator was present on day one, the facility assessment coordinator arranged a conference with the team so that the advisory administrator could discuss findings and recommendations. The advisory administrator and the coordinator then presented findings to the facility in a meeting with the facility administrator. The coordinator always attended this meeting; other team members did so only if they chose.

The facility assessment team--a nurse, a social worker, a sanitarian, and the advisory nursing home administrator and engineer if present on day one--proceeded with a survey which included interviews with key members of staff including nursing aides, housekeeping staff, and kitchen staff. Each member of the team observed at least one meal being served. Team members may have also requested policy books, personnel records, and other information with which to aid their assessment.

The engineer usually was on the survey on day two but may have been there on day one. Day two was preferable because the engineer could then participate in the exit conference with the rest of the team. On the other hand, if the facility was very large or had many physical plant problems, it would be advisable for the engineer to be there on both days.

The resident assessment team included a nurse, a social worker and if needed a physician. Using a computer-generated list of random numbers and an up-to-date census of the home, the person designated as the resident assessment coordinator selected a random sample of residents for the in-depth resident review. The team verified that the sample was representative of the home's population and added any other residents whose care they wished to review. Because the resident sample may have included private pay residents, the team asked facility staff for help in determining which private pay residents were able to sign a release-of-records form as required by state law. Once the sample was drawn, the team first interviewed the residents, followed by an interview with the facility staff and a review of the residents' charts.

In the resident assessment, a scheduled physician was usually present for part of day two. The physician also exited with the rest of the team and presented findings at the exit conference.

The teams met in an executive session on the final day of the survey to share observations and findings. They also agreed upon problem areas to be discussed at the exit conference. The emphasis was on identifying the source of the problems and which state actions would be most likely to resolve the problems. Surveyors also discussed areas in which they felt the home was doing a good job.

As the facility assessment coordinator, the sanitarian led the exit conference with the administrator and staff of the facility. Both facility and resident assessment teams presented findings at this meeting. The teams discussed the problems found and subsequent state actions. The surveyors asked the administrator to indicate actions the home would take to correct the problems found. QAP asked the teams to tape record their conference for future review.

Since follow-up was intrinsic to the QAP process, the survey did not end with the exit conference. Surveyors followed up on their findings and verified that the home had corrected the problems. As a final step, surveyors were to listen to the tape of the summary conference in order to review and critique their own performance, and they discussed any additional follow-up for these completed surveys at the next scheduling meeting.

The scenario used in years one through three can be summarized as follows:

Day 1		Day 2	
<u>RA</u>	<u>FA</u>	<u>RA</u>	<u>FA</u>
RN	RN	RN	RN
SW	SW	SW	SW
	RS	(MD)	RS
	(PE)		PE
	(NHA)		(NHA)

RA = resident assessment

FA = facility assessment

Scenario for Year Four (1981-82). In year four, the scenario was expanded from two or three days to five days and a single survey team replaced the previous two-team approach. The modified survey scenario for fourth year achieved two goals. First, it accommodated the new larger resident sample size. Second, it resolved a previously identified problem of inadequate information exchange between the facility assessment team and the resident assessment team. This survey plan allowed time for the nurse and social worker to complete a larger sample while maintaining the sanitarian as team coordinator.

The new scenario proposal was given to bureau and QAP field staff for their critique prior to its implementation. Many surveyors expressed some negative feelings about the new scenario, particularly in regards to one nurse and social worker surveyor doing both the resident and facility assessments, thus losing the opportunity for exchange of information and ideas among others of the same discipline. Another concern was the increased number of days in the home,

although fewer surveyors were in the home at one time. Project staff considered the criticisms and felt the proposed scenario still was the best approach. Criteria were established, however, for including an extra nurse and social worker.

One resident assessment team was used if:

- .the resident sample size was 20 or less, and
- .the distance from the district office to the facility allowed the screening/sampling to be completed within 5 days.

The combined facility and resident assessment scenario for one team was as follows:

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
<u>RA</u>	<u>RA</u>	<u>RA/FA</u>	<u>FA</u>	<u>FA/EXIT</u>
RN	RN	RN	RN	RN
SW	SW	SW	SW	SW
		(MD)	RS	RS
			(PE)	PE
			(NHA)	(NHA)

RA = resident assessment
FA = facility assessment

Two resident assessment teams were used if:

- .the resident sample size was over 20, and/or
- .the distance from the district office to the facility precluded the screening/sampling from being completed within 5 days.

The combined resident and facility scenario for two teams was as follows:

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
<u>RA</u>	<u>RA</u>	<u>RA/FA</u>	<u>FA</u>	<u>FA/EXIT</u>
RN	RN	RN	RN	RN
SW	SW	SW	SW	SW
RN	(RN)	(MD)	RS	RS
SW	(SW)		PE	PE
			(NHA)	(NHA)

Assessment of Implementation. Although benefits existed for both the years one through three and year four scenarios, it appears that the revised fourth year scenario may have been preferable. Once the new scenario had been implemented, QAP observed surveys and monitored surveyor and facility feedback. No negative feedback was received and surveyors interviewed felt positive about the revisions.

Particularly positive points about the one-team approach are:

- .good carry-over of information from resident assessment to facility assessment; and
- .fewer surveyors in home at once.

Some negative aspects are:

- .surveyors are in home for more days;
- .fewer 'sets of eyes' looking at the facility; and
- .RS, PE and NHA enter on day four and the tour may not be as revealing for them.

C. IN-DEPTH RESIDENT SAMPLING--DESCRIPTION AND IMPLEMENTATION

The Quality Assurance Project philosophy is based on the premise that the State should allocate surveyor time so that more time is spent in homes having problems than in homes providing good quality of care. A key avenue to test the concept of time reallocation was to offer an alternative to the traditional resident assessment process, or inspection of care (IoC), as delineated in the Code of Federal Regulations, 42 CFR 456.611. The inspection process involves an annual review of every Medicaid resident and focuses on adequacy of care received by the resident and on appropriateness of the resident's placement within the facility. During its four-year tenure, the project tested the viability of an in-depth review of a sample of all residents as an alternative to the IoC. We obtained a waiver from the federal government which permitted us to "sample

residents" instead of reviewing all Medicaid residents as required by federal law.

Sampling was intended for use in homes with a history of good performance. The decision to sample in a facility was made at the strategy meeting and was based on file information on the home, such as previous resident assessment results, complaints, and whether there had been a change in key staff. If surveyors decided to sample, they could still decide to switch to the inspection of care at any time during the review.

In the QAP sampling procedure, surveyors looked at the care given a random sample of all residents regardless of their pay type, for example Medicaid, Medicare, private pay, etc. If a home was providing good quality of care to these residents, its care delivery system should assure that good care was being given to all residents. Similarly, if surveyors found residents' levels of care (which relate to reimbursement and staffing) to be accurate, the home's utilization review system should assure that all residents' care levels were accurately set. Data gathered from the sample were aggregated to make an overall assessment about the facility.

Under QAP guidelines, residents included in the sample received a more in-depth review than was traditionally conducted under the inspection of care. A nurse and social worker conducted a team assessment of each resident. The assessment began with an in-depth team interview of the resident. Following the resident interview, the nurse and social worker each conducted an interview of a facility staff member who was involved in direct care delivery, and they reviewed the chart of the resident. During the assessment process, the nurse and social worker shared and discussed their findings.

Essentially, the QAP sampling plan called for surveyors to select at random a sample of all residents in a home. This selection was done through the use of a random number list. Based on the number of residents in the sample whom surveyors found to be placed at an incorrect level of care, the home either passed or failed the sample. If the home passed the sample, no further action was taken. If the home failed the sample, surveyors conducted an inspection of care of all Medicaid residents. A home's past performance at care level accuracy was incorporated into the sampling plan, and surveyors used information gained through the sample to assess both quality of care and level of care.

Project Years One Through Three (1978-81)

QAP tested two variations of the basic sampling plan described above. During years one through three, the home's history at care level accuracy was considered at the strategy session. If surveyors elected to sample, they drew a 10% sample of the home's census or a minimum of ten residents. Based on the number of incorrect care levels found in the sample, the home either passed the sample, failed the sample, or fell into a borderline category. In the latter case, the home's level of care history then determined the

next step. In a home with a good history, no further action was taken. With a borderline history, a second sample was drawn which resulted in either a pass or fail determination. With a problem history, the home was considered to have failed the initial sample and required an inspection of care. (Attachment 6 contains a sample Level of Care Performance Evaluation sheet which reflects the sample sizes and cut-offs used during the first three years.)

The level of care history was initially computed for each home by calculating the percent of care level changes from the two most recent inspections. Numerical cut-offs were established for "good," "average," and "borderline" histories. The worst of the two years was designated the level of care rating. A home's history was updated each year by comparing the home's existing history with the outcome of the last annual inspection. The worst of the two ratings became the home's new level of care history. (See Attachment 7 for a description of how level of care histories were established.)

After three years of testing, a number of problems with the original sampling plan led to its revision. Concerns about the initial plan arose from a variety of sources. Our statistical consultant indicated that the sample size was too small and led to inadequate confidence levels. The procedure for computing level of care histories was artificially locking many homes into the "borderline" category. The definitions of good, average, and borderline histories were out of date. Lastly, our monitoring data were suggesting that surveyors were prematurely passing the sample, possibly to avoid conducting the inspection of care. (Attachment 8 contains a detailed description of these problems and the rationale behind the revised sampling plan.)

Project Year Four (1981-82)

For the fourth and last project year, QAP increased the sample size and simplified the sampling plan. The sample size was increased to a variable percentage depending on size of the home; for example, an average size home of 100 had a sample size of 20. (Attachment 9 contains the revised Level of Care Performance Evaluation sheet which reflects the new sample sizes and error cut-offs.) The second sample option was eliminated, and we switched to a single sample with either a pass or fail outcome.

Computation and use of the level of care history also changed. We switched to a weighted, three-year average to compute the history, and the history was used on the front end as a "core criterion" to determine whether to sample. Sampling was used in homes with a good or average history. In homes with an average history bordering on a problem rating, a more stringent sampling plan was recommended. In homes with a problem history, surveyors were required to automatically schedule an inspection of care. (See Attachment 8 for a complete description of the revised procedures for computing level of care histories.)

Physician Role

The physician's role in the QAP resident assessment process was to evaluate all residents in the sample and help the survey team make two sets of decisions. First, is the home delivering inadequate care in any area? If so, what steps should be taken to remedy this situation? Second, is the home properly assigning levels of care? If not, what steps should be taken?

The QAP resident assessment process contained three primary changes for the role of the physician:

1. Only a representative sample of residents was reviewed in the initial screening effort.
2. The physician reviewed all residents in the sample, including ICF as well as SNF level residents and Medicare or private pay residents as well as Medicaid. In the federal IoC process carried out by the Bureau, the physician reviewed the care of only SNF Medicaid residents.
3. A new form was used to record the results of the assessments (see Attachment 10).

When the physician conducted QAP resident assessments, he or she was to review the chart and the plan of care for each of the sample residents, concentrating on the involvement of the attending physician, utilization of diagnostic tests, prescription and dispensing of medications, and the quality of medical recordkeeping. The physician was also consulted on the need for a change in level of care or in alternate placement if either was indicated.

Upon arrival at the nursing home, the physician would be presented with resident assessment forms which had already been partially completed by the nurse and social worker. Physician activities included reviewing the chart, observing as many residents in the sample as possible, and interviewing the medical director, attending physician, and/or facility staff. The physician completed the MD portion of the resident assessment forms.

The physician was then to meet with the team to summarize resident assessment findings and to exit with surveyors and facility medical staff and nursing directors. The physician also completed a form summarizing overall impressions of the medical care delivered in the facility.

In the spring of 1979, QAP staff began receiving requests from the surveyors for physicians to serve as consultants to nursing homes or as special advisors to the survey team. This change expanded the physician's role to include a fourth component: consultant to the team or the facility.

Study Number One: A Summary of Level of Care Errors and Sampling Outcome in Project Years One Through Three

Study Intent. When the project initiated the new resident assessment method in each demonstration district, the outcome of resident sampling was routinely monitored by project staff. This monitoring permitted us to be alert to potential problems in implementation of QAP sampling. Data collected included number of homes sampled and passed, number of homes failing the sample, and number of homes in which surveyors opted to switch from sampling to inspection of care. In each of these three categories, we calculate the percentage of residents reviewed whom surveyors judged to be at an incorrect level of care. Where available, results in homes eligible for sampling were compared to old method homes receiving the inspection of care. Data collected were published and discussed in each of the project's three annual reports.

Findings. Table 4 summarizes all monitoring data on sampling which the project collected during its first three years. All data are based on the original 10% sampling plan which was tested during this time period.

Table 4

Summary of Level of Care Errors and Sampling Outcome in Years One Through Three

District/Year	Percent of Residents Misclassified in Homes Eligible for Sampling								Percent of Residents Misclassified in Inspection of Care Homes	
	Passed Sample		Failed Sample		Switched to IOC		Total			
	# homes	%	# homes	%	# homes	%	# homes	%	# homes	%
Rural Districts										
Year 1 (1978-79)	51	10%	8	18%	5	24%	64	16%	71	14%
Year 2 (1979-80)	43	2%	9	17%	3	7%	55	9%	55	12%
Milwaukee District										
Year 1 (1979-80)	16	3%	1	15%	2	37%	19	10%	20 (0/0)	14%
									23 (Con.)	24%
Expansion Districts										
Year 1 (1980-81)										
Green Bay	25	8%	8	16%	16	15%	49	13%		
Madison	73	7%	9	17%	-	-	82	11%		NA

Several trends are apparent in this summary table. First, the great majority of homes eligible for sampling receive and pass the sample. With the exception of the Green Bay district, over 80% of the homes receive and pass the sample. In Green Bay, only half the homes eligible for sampling (25 of 49) both received and passed the sample. Second, in homes that fail the sample, results of the inspection of care show a slightly higher than average rate of care level errors. In the rural districts, homes that failed the sample had an average error rate of 18% in year one and 17% in year two as compared to old method homes which averaged 14% and 12% respectively. However, in the Milwaukee district, this pattern was reversed, and homes that failed the sample averaged 15% of their residents misclassified, about the same as the 14% error rate in O/O homes and less than the 24% error rate in control homes. In the expansion districts, there were no within-district comparison groups.

A third trend is a considerable variation between districts on most all measures. Percentage of residents found to be misclassified in the sample ranged from 2% in the Milwaukee district to 10% in the first year in the rural districts. The proportion of homes failing the sample ranged from 8 of 49 (16%) in the Green Bay district to 1 of 19 (5%) in the Milwaukee district. The proportion of new method homes which surveyors switched to full inspection ranged from none of 82 homes in the Madison district to 16 of 49 homes (32%) in the Green Bay district.

Conclusions. Monitoring results raised some concerns among project staff. During the second project year (1979-1980), the majority of homes passed the sample, and sampled residents had an atypically low percentage of level of care (LOC) errors. This outcome suggested that perhaps surveyors were prematurely passing the sample or choosing to sample in homes which should be switched to inspection of care. Also, in homes that failed the sample, the inspection of care showed only a somewhat higher percent of residents at incorrect levels of care as compared to the average error rate found in old method homes. This finding was contrary to expectations since only homes with problems at setting care levels would be expected to fail the sample.

Lastly, the variability between districts in choosing to sample or to switch to full inspection suggested a lack of uniformity in application of new method procedures. In response to these concerns, QAP staff instituted use of core criteria to aid in the decision to switch methods (see Chapter II, Section A) and revised its resident sampling procedures.

Study Number Two: A Comparison of Frequency of Level of Care
Errors and Sampling Outcome Under QAP's
Original and Revised Sampling Plans

Study Intent. The project implemented its revised resident sampling plan effective October 1, 1981. In order to monitor the effect of this change, data were collected for a time period before and after the revised plan was implemented. We monitored the effect of the revised sampling plan on number of homes that passed and failed the sample and the percentage of incorrect care levels found in these homes. For comparison purposes, we also looked at homes in which surveyors opted to switch to inspection of care.

It was anticipated that the more rigorous sampling plan would discriminate better between homes in their ability to accurately set care levels. The sample size had been increased, and the number of incorrect levels of care allowed within the sample was lowered. Potential outcomes that could result from these changes include an increase in number of homes failing the sample and a corresponding decrease in number of homes passing the sample. A larger percentage of incorrect care levels might also be found in homes that pass the sample, and an inspection of care in homes which failed the sample should confirm that these homes did in fact have an atypically high number of incorrect care levels.

Data were collected from the Green Bay and Madison expansion districts and from the Milwaukee district. In the expansion districts, results from new method homes inspected under the last six months of the original sampling plan, April 1981 through September 1981, were compared to results from new method homes inspected under the first six months of the revised sampling plan, October 1981 through March 1982. For comparison purposes, results from Madison district homes assigned to the O/O treatment cell were also included for the time period of October 1981 through March 1982. Effective October 1, 1981, these homes, which had formerly been assigned to the O/N treatment cell, returned to inspection of care (O/O).

In the Milwaukee district, results were collected for both N/N and O/O homes. Since Milwaukee district homes ended their third year in the project and returned to full survey and inspection (O/O) on March 1, 1982, the time period of the comparison was modified. Results from the last six months of testing of the original sampling plan, April 1981 through September 1981, were compared to results from the first five months of use of the revised sampling plan, October 1981 through February 1982. In O/O homes in the Milwaukee district, results of the inspection of care are also reported for the same time period for comparison purposes.

Findings. Results from the expansion districts are shown in Table 5.

Table 5

A Comparison of Level of Care Errors Under QAP's
Original and Revised Sampling Plan in the
Expansion Districts

District/Method/ Time Period	Percentage of Residents Misclassified in Homes Eligible for Sampling								Percentage of Residents Misclassified In IOC Homes	
	Sampled and Passed		Failed Sample		Switched to IOC		Total			
	# homes	%	# homes	%	# homes	%	# homes	%	# homes	%
Green Bay-New 4/81-9/81	12	3.0	7	16.5	7	14.3	26	13.7		
vs. 10/81-3/82	19	9.1	0	--	10	13.8	29	12		NA
Madison-New 4/81-9/81	32	2.6	7	18.3	1	3.3	40	11.2		
vs. 10/81-3/82	14	10.2	4	12.3	1	16.9	19	12.3		NA
Madison-Old 10/81-3/82									18	10.5

Only one of the anticipated outcomes was observed. The percentage of residents found to be at incorrect care levels increased in homes which were sampled and passed. In the Green Bay district, the percentage of observed incorrect care levels increased from 3% to 9.1%. In the Madison district, the percentage of observed incorrect care levels increased from 2.6% to 10.2%.

However, the significance of this increase needs to be considered in the context of first-year results from the expansion districts. As shown in Table 4, the average level of care (LOC) error rate in homes that passed the sample during the first year of operation was 8% in the Green Bay district and 7% in the Madison district. Thus, the 3% and 2.6% LOC error rates observed during the first half of the second year were actually a decrease compared to the first year. With implementation of the revised sampling plan, the average LOC error rate in homes that passed the sample rose to a level only 1-3% higher than it had been during the first year.

The number of homes failing the sample showed little overall increase. In the Green Bay district, the proportion of homes failing the sample decreased; 7 of 19 sampled homes (37%) failed the sample under the original sampling plan vs. none of 19 sampled homes under the revised sampling plan. In the Madison district, the proportion of homes failing the sample showed a slight increase, 7 of 39 homes (18%) under the original plan and 4 of 18 homes (22%) under the revised plan.

In addition, there was a decrease in percentage of incorrect care levels found in homes which failed the sample. In the Green Bay district, no homes failed the sample after the revised plan was implemented. Under the revised plan, level of care error rates in the Madison district dropped from 18.3% to 12.3%.

Percentage of LOC errors found in homes where surveyors decided to switch to the inspection of care are also shown in Table 5. In the Green Bay district, surveyors increased the number of homes in which they decided not to sample. During both time periods, the inspection of care showed an average LOC error rate of approximately 14%. In the Madison district, surveyors switched only one home to full review during each time period, and the LOC error rate in each home was distinctly different, 3.3% vs. 16.9%.

Little change was noted in overall LOC error rate as a result of implementation of the revised sampling plan. In the Green Bay district, the average LOC error rate was 13.7% under the original plan and 12% under the revised plan. In the Madison district, the overall LOC error rate was 11.2% under the original plan and 12.3% under the revised plan. However, this percentage exceeded the percent LOC error rate (10.5%) found in old method homes in the Madison district.

Results from the Milwaukee district are shown in Table 6.

Table 6

A Comparison of Level of Care Errors Under QAP's
Original and Revised Sampling Plan in the
Milwaukee District

Treatment Cell/Time	Percentage of Residents Misclassified in Homes Eligible for Sampling								Percentage of Residents Misclassified in IOC Homes	
	Sampled & Passed		Failed Sample		Switched to IOC		Total			
	#	%	#	%	#	%	#	%	#	%
Period	homes	%	homes	%	homes	%	homes	%	homes	%
N/N										
4/81 - 9/81	8	2.0%	1	15.6%	0	-	9	8.2%		
vs.										
10/81 - 2/82	6	8.3%	1	22.1%	1	0	8	13.6	NA	

0/0			
4/81 - 9/81		18	15.4%
vs.	NA		
10/81 - 2/82		18	13.9%

Findings from the Milwaukee district are more in line with anticipated outcomes. However, the number of homes is relatively small.

The most apparent trend is an increase in the percentage of LOC errors found in homes which passed the sample. Under the original sampling plan, 2.0% of the residents reviewed were classified at incorrect levels of care. Under the revised sampling plan, 8.3% of the sampled residents were found to be misclassified. This increase is also maintained when compared to first year results from the Milwaukee district as shown in Table 4. During the first year of operation under the original sampling plan, 3% of the residents reviewed were misclassified in homes which received and passed the sample.

The proportion of homes failing the sample increased slightly from 11% (1 of 9) to 14% (1 of 7). There was an increase in percentage of LOC errors found in homes that failed the sample. Under the original sampling plan, an inspection of care in the home that failed the sample showed an error rate of 15.6%. Under the revised plan, the one home which failed the sample had an error rate of 22.1%.

Surveyors did not switch any new method homes to inspection of care during the first time period. Only one home was switched during the second time period, and this home had no residents placed at incorrect levels of care.

In all homes eligible for sampling, the average LOC error rate increased following implementation of the revised sampling plan, and this increase corresponded more closely with results from old method homes. Under the original plan, 8.2% of the residents reviewed were misclassified. This percentage was considerably less than the 15.4% error rate found in old method homes during the same time period. Under the revised sampling plan, 13.6% of the residents reviewed were judged to be misclassified. This percentage more closely approximates the 13.9% observed in old method homes during the same time period.

Conclusions. Percentage of residents placed at incorrect care levels and the outcome of sampling were compared under the original and revised sampling plans in the Green Bay, Madison, and Milwaukee districts. It was anticipated that the revised sampling plan would be more rigorous and that there would be an increase in number of homes failing the sample and/or an increase in percentage of incorrect care levels found as a result of the larger sample size and lower cut-offs for failing the sample. However, the anticipated outcomes occurred only in part.

1. In two of three districts, number of homes failing the sample showed a small increase under the revised sampling plan as compared to the original plan. In the Madison and Milwaukee districts, there was a small increase in proportion of homes failing the sample. In the Green Bay district, the proportion of homes decreased.
2. In homes that failed the sample under the revised sampling plan, results of the inspection of care also varied by district. In the Green Bay and Madison districts, the observed percentage of incorrect care levels actually decreased under the revised plan as compared to the original sampling plan. However, in the Milwaukee district, the expected increase was observed, and the percentage error rate found by the inspection of care confirmed that these homes had atypically large numbers of residents at incorrect care levels.
3. The percentage of residents found at incorrect care levels in homes that received and passed the sample increased in all districts upon implementation of the revised sampling plan. This increase was very systematic in all districts, increasing from about 3% to 9%. However, in the expansion districts, this increase amounted to only a small increase over the pattern observed in their first year of sampling under the original sampling plan. In the Milwaukee district, the increase was more lasting as compared to its first year of operation.

These data suggest that other unknown factors are operating. There appears to be a strong element of surveyor judgment or discretion entering into the sampling plan. These judgments may be based on such factors as overall quality of care in the home, surveyor workload, etc. The findings indicate a need to further explore what variables are influencing the outcome of sampling beyond the home's ability to maintain accurate care level determinations.

Study Number Three: Post-Monitoring of Level of Care Errors in the Rural Districts

Study Intent. For three years - April 1978 through March 1981 - the project tested its four treatment cells in the rural districts of La Crosse, Eau Claire, and Wisconsin Rapids. All homes in each of the districts were randomly assigned to the N/N, N/O, O/N, and O/O cells. In April 1981 the districts returned to the full survey and inspection of care. These circumstances provided us with a valuable opportunity to compare the homes based on their previous treatment cell.

From April 1981 through March 1982, QAP monitored results of the annual inspection of care and tabulated frequency of residents found at incorrect care levels. Results were averaged and compared based on the homes' former treatment cell.

Findings. Results are shown in Table 7.

Table 7

Frequency of Level of Care Errors
in the Rural Districts, April 1981-March 1982

Former Method	# Homes	# Reviews	% Care levels too high	% Care levels too low	Total care level errors
QAP (N/N, O/N)	58	5,078	8.8%	3.7%	12.5%
Inspection of Care (N/O, O/O)	61	3,536	7.7%	4.2%	11.9%

These findings suggest virtually no difference between homes based on their previous method of resident review. There is only a difference of .6% on total number of incorrect care levels, 12.5% in former new method homes versus 11.9% in former old method homes. There is a slight difference in percent of care levels set too high, 8.8% in former new method homes versus 7.7% in former old method homes. Lastly, there is little difference in percent of care levels set too low, 3.7% in new method homes versus 4.2% in old method homes.

Conclusions. QAP sampling appears to have had no impact on homes' ability to maintain accurate resident care levels during its three years of operation in the rural districts. The largest difference was a 1% difference in percentage of care levels which surveyors determined to be set too high. Although this difference is too small to be of any consequence, it may suggest the need to closely monitor a home's performance were QAP methods to be used over a longer period of time.

Number of violations cited were also included in rural district post-monitoring. Homes formerly eligible for QAP sampling were compared to homes formerly assigned to the old method treatment cell. No differences were found in number of violations issued, and results are discussed in this chapter in Section D, "Screening for Quality."

Impact of Sampling on Medicaid Nursing Home Reimbursement

In Wisconsin, There are currently five levels of care; skilled nursing care (SNF) and four levels of intermediate care (ICF 1, 2, 3, and 4). These levels are a key factor influencing the rate of Medicaid reimbursement received by a nursing home. They also relate to computations for state staffing requirements.

In summer 1981, the project initiated a preliminary study of nursing home reimbursement dollars lost or gained as a result of sampling. It was conducted under the direction of our project consultant at the University of Wisconsin Statistical Laboratory. The study compared differences in rate of reimbursement before and after the resident review in a sample of homes receiving new and old methods. It examined total dollars saved by the state per resident reviewed and the potential savings lost for those residents not reviewed, i.e., not included in the QAP in-depth sample. Preliminary findings were reported to Bureau of Quality Compliance supervisors in January 1982. Due to amount of interest in the study and to other questions still left unanswered this initial study was significantly expanded.

The Bureau of Evaluation in the Wisconsin Division of Policy and Budget was responsible for the expanded analysis of the effect of QAP sampling on nursing home reimbursement. The study focused on three important questions:

1. What is the comparative cost or savings to the state in nursing home reimbursement under the "old" inspection of care and under the "new" QAP sampling method?
2. What is the comparative administrative cost of conducting the "old" inspection of care and the "new" sampling method?
3. What is the net savings or cost to the state in nursing home reimbursement after taking into consideration the cost of conducting the review under the "old" and "new" methods?

The final report, entitled "An Analysis of the Effect of Wisconsin's Inspection of Care Reviews on Medicaid Nursing Home Reimbursement" is contained in Attachment 11. The report concluded that:

1. Inspection of care reviews are cost beneficial regardless of whether conducted under QAP or the old method.
2. There is little difference between the methods in their net savings to the State. QAP sampling is not losing nursing home reimbursement dollars as compared to the old method.
3. Nursing homes that pass the QAP sample have a substantial savings per resident reviewed and thus residents not reviewed may represent large sums of unrealized savings.

As a follow-up to their original study, the Bureau of Evaluation conducted two additional studies to further clarify the effects of level of care determinations under the mandated inspection of care and QAP sampling. QAP staff assisted in identifying issues to be studied and collected the necessary data; results were analyzed and reported by staff within the Bureau of Evaluation. Copies of the final reports are contained in Attachments 12 and 13.

The first follow-up study addressed two questions. (1) Did QAP sampling result in a disproportionately larger percentage of skilled care (SNF) residents being lowered to intermediate care levels (ICF) as compared to the inspection of care? (2) Under the QAP sampling plan, do fewer homes fail the sample than would be expected?

In regard to the first question, the study concluded that:

- (1) "The QAP method (sampling) of resident review is likely to result in a net lowering of SNF levels of care four times that of the federally mandated method."
- (2) "Under the QAP method, nursing homes that 'pass' the sample have similar percentage reductions in SNF levels as homes that do not pass the sample. This suggests that the QAP sampling method does not adequately identify the homes with level of care problems."

In regard to the second question, the study concluded that:

- (1) "Only one-third as many nursing homes fail the sample under the QAP as expected."
- (2) "Five times as many homes have zero level of care errors as expected."

The second follow-up study was an analysis of results of applying the inspection of care method of resident review on a sample basis in the rural districts in May and June 1982. QAP had instituted this test in order to better interpret the earlier finding that nursing homes passing the QAP sample had a similar percentage of SNF reductions as those not passing the sample. It was not clear whether this outcome was due to the QAP in-depth method of review or was an unintended artifact of sampling.

The study concluded that sampling appears to be a factor in QAP's tendency to lower SNF care levels but to what extent was not clear. The major limitation to the study was the small number of homes (22) available for analysis.

D. SCREENING FOR QUALITY--DESCRIPTION AND IMPLEMENTATION

Under the QAP model, problem areas are quickly identified via a screening process which was developed by Wisconsin health care professionals and experts in long-term care regulation. The facility assessment allowed surveyors to screen a home in critical care areas and to pinpoint those areas in which the home is experiencing problems. Survey time was then to be spent in diagnosing the source of the problems and in prescribing state actions to remedy them. During screening, surveyors were not expected to be looking in detail at every code area.

The surveyors used a screening assessment worksheet (see Attachment 14) which contained the ten care areas. The items on this form were not changed over the four years of the demonstration. When surveyors met in the pre-exit conference, they jointly completed a composite facility assessment (see Attachment 15).

The screening process was to require approximately two days and replaced the mandated state and federal regulation checklist. It was intended to focus more on quality care provided by the nursing home and less on paperwork requirements. It was also intended for use in homes with a history of code compliance and a willingness to respond to state actions.

When surveyors found compliance problems during screening, they cited deficiencies/violations. However, in addition, they chose from a range of other options which included informal advice, consultation, or inservice, which may help a home improve the quality of care.

Federal and state codes specify minimum requirements which nursing homes must meet. When these codes are not met, deficiencies (of federal regulations) or violations (of state regulations) are cited. Federal deficiencies are not classified by severity. However since November 1977, there have been three classifications by which state code violations must be labeled and for which forfeitures may be assessed pursuant to Chapter 50 of the Wisconsin Statutes. These are:

Class A - a substantial probability that death or serious mental or physical harm to the resident will result therefrom (forfeiture potential: \$1,000-\$5,000/day);

Class B - directly threatening to the health, safety or welfare of a resident (\$100 - \$1,000/day);

Class C - does not directly threaten the health, safety or welfare of a resident (\$10 - \$100/day).

Any federal deficiencies or state codes to be cited were recorded on a state Notice of Violation form, following regular bureau procedures. As the QAP citing policy changed effective October 1, 1981, citing will be discussed as it was carried out in years one through three and in year four. The citing policy for federal codes remained the same throughout the course of the demonstration.

State Codes

Years One through Three. From the beginning of the project until October 1981, direction given to surveyors at training sessions on QAP citing policy was somewhat inconsistent with what was contained in the Procedure Manual and also changed to some extent over time.

This was in part due to the fact that during the development of project procedures and project implementation, the Bureau was adjusting to a major November 1977 change in the state nursing home statute and clarifying its citing policy. Whether or not the project required a "waiver" of the statute to carry out its use of alternate actions to citing was not clear until part way through the project's first year. At that time, a legal opinion made it clear that surveyors were required to cite all state violations observed. An attempt was made then to reconcile project methods with state enforcement requirements.

While the QAP Procedure Manual stated that all violations or deficiencies observed during screening should be cited, surveyors were told that, under certain circumstances, non-serious violations (or those that would be classed as C violations under state definitions) could be dealt with through the use of alternate actions without resorting to citing unless the facility failed to correct within a reasonable timeframe. QAP surveyors were to verify that problems had been corrected or they were to cite if the problems had not been corrected within the given timeframe.

Although QAP surveyors were given the option not to cite non-serious "Class C" violations, there were instances when these violations were to be cited. For example, QAP training stressed that when a problem was discovered in a facility that did not adversely affect resident care, but had the potential to intensify and pose a threat to resident care, surveyors should cite the violation.

During training sessions, QAP surveyors had also been instructed to choose the most effective follow-up action to bring about change and problem correction. If, for example, it was likely that the facility administrator or Board of Directors would correct a problem

only if it was cited as a violation, surveyors were to use citing as the best problem correction strategy.

At the initial training sessions in the rural and urban districts, use of actions other than citing was stressed, perhaps almost to too great an extent. The pendulum swung in the other direction in the training sessions for the expansion districts, and emphasis was placed to a much greater extent on use of the home's history as a reason to carry out a full or partial compliance survey.

Throughout this time, the Bureau's citing policy was also being clarified. At the time of QAP's field testing start-up, Bureau "old method" surveyors were directed to determine whether a violation existed and cite all violations observed.

In 1979 the concept of "substantial compliance" began to evolve in the Bureau. For Class C level "violations", if the facility had complied substantially with the code, a violation need not be cited. This concept moved the Bureau closer to QAP procedures, but still did not enable use of alternate actions for Class C violations that were not in substantial compliance.

Year Four. Effective October of 1981, QAP citing policy came into line with the bureau citing policy for state codes on the advice of legal council. Whenever a state code violation was observed (during the course of screening, of further investigation, or when a partial or full code survey was being carried out), regardless of whether or not there was direct impact on resident care, the violation was to be cited.

In addition, surveyors were to employ added alternate actions that would best help the facility to correct the problem.

Changes in state statute occurred in February 1982 which formally authorized the concept of substantial compliance. At that time, surveyors could use discretion in citing Class C violations if the facility was in substantial compliance with the state code. Additionally with this statute change, surveyors could choose not to cite a violation if it was brought to the attention of the Bureau by the facility and the facility had made every reasonable effort to prevent and correct it.

The ambiguity and change in the QAP and bureau citing policy on state codes has had an impact on the full implementation and testing of "alternate actions to citing" and is reflected in the monitoring studies.

Federal Codes

QAP had federal waivers to enable the use of alternate actions to correct non-serious federal deficiencies. All deficiencies of federal codes that were not cited were to be documented and treated with the use of alternate actions to citing. Surveyors were to

verify that problems had been corrected, or they were to cite if the problems had not been corrected within a reasonable timeframe. There was no change in the federal code citing policy throughout the course of the demonstration.

Assessment of Implementation

While two days were given as a guideline for the amount of time needed to screen an average size facility, QAP staff often observed surveyors conducting a two to three day mini-full survey rather than screening. Even when screening did not suggest problems, surveyors often focused on the home's paperwork and spent a significant portion of time on documentation review.

Some surveyors said they saw little difference between the new and old survey methods. This is perhaps because of the tendency of many surveyors to add to or change the QAP screening survey so that it more resembled a full survey than a screening technique.

Study Number One: A Summary of Citation Data Collected During Project Years One Through Three

Study Intent. With implementation of QAP methods in each of the demonstration districts, QAP staff monitored the number and severity of violations/deficiencies cited. We calculated average number of Class A, B, and C violations and federal-only deficiencies cited per home and compared results from all treatment cells. These data permitted project staff to monitor the implementation of QAP facility screening procedures.

During the first three years of the demonstration, QAP predicted that fewer "paper compliance" deficiencies would be cited overall under the new methods. If this was true, the number of Class C (state) and federal elements cited should be less in new method homes as compared to old method homes. On the other hand, the new methods were presumed to be able to detect major problems equally well, so that the frequency of Class A and B violations and serious federal deficiencies should not differ between survey methods. These hypotheses were tested between July 1, 1978, the date of project start-up, and October 1, 1981, when QAP implemented its revised policy on citing of state violations.

Due to the rate at which the project expanded into six of the State's eight surveyor districts and the limited number of QAP staff available to collect monitoring data, QAP focused its monitoring efforts on start-up periods in each of the QAP districts.

Findings. Citation data collected by the project are summarized in Table 8. This table is a synopsis of data presented and discussed in the QAP Annual Reports published in 1979, 1980, and 1981. These figures include all violations cited in homes assigned to the indicated treatment cells, from both annual and interim surveys. Since the hypotheses involved a comparison in problem detection, all violations and deficiencies cited, whether on an annual or interim visit, were included.

Table 8

Summary of Citation Data Collected in N/N and
O/O Method Homes During Project's First Three Years

District/ Year/Treatment Cell	Average Number of Citations Issued per Home by Class*			Federal Deficiency	
	A	B	C	Only	Total
Rural Districts					
Year 1 (1978-79)					
N/N	-	.8	6.0	1.4	8.2
O/O	-	.5	11.3	2.8	14.6
Year 2 (1979-80)					
N/N	-	.1	3.3	.4	3.8
O/O	-	.4	7.5	1.8	9.7
Milwaukee					
Year 1 (1979-80)					
N/N	.1	1.2	4.6	1.1	6.9
O/O	.1	1.2	10.5	2.1	13.8
Cont.	.1	1.4	11.2	2.3	15.0
Green Bay					
Year 1 (1980-81)					
N/N	-	.2	2.6	.3	3.1
Madison					
Year 1 (1980-81)					
N/N	-	.1	2.2	.4	2.8

*Number includes all violations/deficiencies cited on both annual and interim surveys.

Citation monitoring data collected by the project generally confirmed the initial hypotheses. First, N/N homes received fewer Class C violations and federal-only deficiencies than did O/O homes. This trend was apparent in the first and second year of operation in the three rural districts of La Crosse, Eau Claire, and Wisconsin Rapids. It was also true in the first year of operation in the urban Milwaukee district. Although the Madison and Green Bay districts did not contain within-district control groups, N/N homes in these districts were receiving noticeably fewer Class C violations and federal-only deficiencies than were old method homes in the rural and urban districts.

Second, there were little or no differences in frequency of serious citations issued in N/N and O/O method homes. In all demonstration districts, there were no differences in frequency of Class A violations cited. Differences in frequency of Class B violations

were limited to a narrow range of .2 to .3 per home between the treatment cells.

However, two other unpredicted trends were also apparent in the data collected. First, in the rural districts, there was a pronounced drop in number of citations in both N/N and O/O homes between the first and second year. (This outcome paralleled a trend which was occurring statewide.) Second, there was a marked degree of variation between districts in frequency of citations. Both of these trends suggest the influence of factors other than the QAP screening methods, such as differences between districts in application of the codes and in quality of the homes.

Conclusions. Predicted outcomes in citing patterns were observed. QAP surveyors cited fewer "paper compliance deficiencies/violations" (i.e. Class C violations and federal-only deficiencies) as compared to old method surveyors. They also detected major problems equally well, and there was no difference between methods in number of Class A and B violations cited.

Study Number Two: A Comparison of Frequency of Citations Issued Before and After the Change in QAP Citing Policy

Study Intent. Shortly after the beginning of the project's fourth year, a number of changes were introduced both in QAP policy and in home assignment to experimental treatment cells. One of the expected outcomes of these changes was a difference in frequency of violations/deficiencies issued. On October 1, 1981, QAP revised its citing policy for homes eligible for new method screening. This change affected N/N homes in the Madison, Green Bay, and Milwaukee districts. On October 1, O/N method homes in the Madison district returned to the O/O treatment cell. On March 1, 1982, homes in the N/N treatment cell in the Milwaukee district completed their three years in the project and returned to full survey and inspection, O/O.

We monitored implementation of these "fourth year" changes by comparing frequency of citations issued in the months prior to the changes as compared to after the changes. In the Madison and Green Bay districts where the effective date of the changes was October 1, 1981, we compared frequency of citations in the last six months prior to the changes (April-September 1981) to the first six months after the changes (October 1981 through March 1982). In the Milwaukee district where N/N homes ended in March 1982, our comparison of the effects of changes in the QAP citing policy was limited to April-September 1981 vs. October 1981 through February 1982. Citations included in this study were limited only to those cited on annual surveys.

If the citing policies were implemented as prescribed, the following outcomes would be expected when comparing the two time periods.

- (1) In homes assigned to the N/N treatment cell in the Madison and Green Bay districts, there would be:

- an increase in average number of state Class C violations cited, since QAP switched from allowing alternate actions on non-serious Class C violations to requiring citing of all observed violations of state code; and

- no change in frequency of federal-only deficiencies cited, since QAP's federal waiver continued in effect.

- (2) In Madison homes assigned to the O/N treatment cell and then switched to the O/O cell, there would be an increase in frequency of citations issued. Project staff had informed surveyors that QAP citing guidelines could be applied to all violations/deficiencies identified during the new method resident sampling process.

- (3) In Milwaukee district homes assigned to the N/N treatment cell and then switched to the O/O cell, there would be:

- an increase in state Class C violations since the QAP option not to cite non-serious Class C violations was replaced with the bureau citing policy which required that all violations of state code be cited; and

- an increase in federal-only deficiencies cited since QAP's federal waiver was no longer applicable for those homes.

- (4) In Milwaukee district homes assigned to the O/O and control cells, there would be no changes in frequency of citations issued since no policy changes or changes in treatment cell were implemented.

Note: In no case would changes in frequency of Class A or B violations be expected since there were no changes in policy and both QAP and bureau policy require citing of all Class A and B violations.

Findings.

Table 9

A Comparison of Average Number of Citations Issued
in the Expansion Districts Before and After
the Change in Citing Policy

Class of Violation						
District/Year	# Homes	A	B	C	Federal	Total
					Deficiency Only	
Madison N/N						
Before (4-9/81)	18	0	0	2.6	.3	2.9
After (10/81-3/82)	19	0	.1	5.4	.9	6.4
Green Bay N/N						
Before (4-9/81)	26	0	.1	3.6	.8	4.5
After (10/81-3/82)	29	0	.4	8.4	.9	9.7
Madison						
O/N (4-9/81)	19	0	0	2.6	.5	3.1
O/O (10/81-3/82)	20	0	.1	5.4	1.4	6.8

In N/N homes in Madison and Green Bay, the expected outcomes were observed. Average number of Class C violations increased from 2.6 to 5.4 per home in the Madison district and from 3.6 to 8.4 per home in the Green Bay district. Both districts showed little change in federal-only deficiencies cited, averaging less than one deficiency per home.

In Madison district homes which switched from the O/N to O/O treatment cells, the expected increase was also observed. The average number of Class C violations more than doubled, increasing from 2.6 per home to 5.4 per home. The number of federal-only deficiencies also increased from .5 to 1.4 per home. The net effect was that total number of violations cited doubled, from 3.1 to 6.8 per home.

Results from the Milwaukee District are shown in Table 10.

Table 10

A Comparison of Average Number of Citations Issued
in the Milwaukee District Before and
After the Change in Citing Policy

Class of Violation						
Treatment Cell/Year	# Homes	A	B	C	Federal Deficiency Only	Total
N/N						
Before (4-9/81)	10	0	.4	2.3	.7	3.4
After (10/81-2/82)	8	0	.5	3.0	.4	3.9
O/O						
Before (4-9/81)	10	0	.4	6.6	.6	7.6
After (10/81-2/82)	9	0	.1	4.7	.7	5.5
Control						
Before (4-9/81)	10	0	.1	4.8	.9	5.8
After (10/81-2/82)	15	0	.3	5.9	.8	7.0

Observed trends in the Milwaukee district are particularly variable by cell. Some of the trends are in the expected direction while others are in the opposite direction. This variation makes interpretation of the findings more difficult. It may be due in part to the relatively smaller number of homes within each time period.

In N/N homes, there was a minimal increase in number of Class C violations cited, contrary to what would be expected. Average number of Class C violations increased from 2.3 to 3.0 per home, less than one more violation per home. However, as anticipated there was no increase in number of federal-only deficiencies cited, ranging from .7 to .4 per home.

In O/O and control homes where no differences would be expected between the two time intervals, O/O homes decreased in number of Class C violations while control homes increased. In O/O homes, the number of Class C violations decreased from 6.6 to 4.7 per home, approximately two less violations per home. In control homes, the number of Class C violations increased slightly, from 4.8 to 5.9 violations per home. However, the number of federal-only deficiencies remained stable during the 12-month period in both cells. Homes averaged less than one deficiency per home.

Conclusions. In N/N homes in the Madison and Green Bay districts, the change in QAP citing policy appears to have been implemented as specified. When QAP discontinued its option to take alternate actions to citing on non-serious state Class C violations and adopted the bureau citing policy that required that all state code

violations be cited, the number of Class C violations increased. However, QAP surveyors continued to use the federal waiver which enabled them to select alternate actions to citing non-serious federal-only deficiencies, and there was no change in number of federal-only deficiencies issued.

In the Milwaukee district, findings were erratic. In N/N homes, surveyors continued to use the QAP waiver on federal-only deficiencies as appropriate. However, they also appear to have continued to use the former QAP option not to cite Class C violations although the policy was no longer in effect. In O/O and control homes, there were inconsistent and unanticipated increases and decreases in number of violations cited. There is no apparent explanation for these differences. Since the number of homes was relatively small in all intervals and cells, results from this district may be more home-specific and less representative of major trends in surveyor practices.

Study Number Three: A Comparison of Frequency of Repeated Problems in New and Old Method Homes

Study Design. The purpose of the study was to determine whether new method surveys result in fewer repeated problems from one annual survey to the next as compared to old method surveys. Problems were defined as any shortcoming (code and non-code related) identified by surveyors in the home and formally reported by the Bureau of Quality Compliance. A "repeat" was a problem involving the same category of health care provider, the same deficient action or process and the same outcome or potential outcome.

Thirty-two homes from the rural districts and 13 homes from the Fond du Lac district were included in the study. From the three rural districts, 18 homes were N/N and 14 homes were O/O. The 13 homes from the Fond du Lac district were O/O homes which were used as an additional comparison group.

The time period covered by the study was restricted to 1978 and 1979. During these years, both QAP and the Bureau of Quality Compliance surveyor assignments rotated between annual surveys. In the preceding and subsequent year, surveyor rotation did not occur in both methods, and this difference could potentially contaminate the results of the study. Since different surveyors have different priorities and styles in problem identification, it seemed likely that having the same or different surveyors from year to year could increase or decrease the probability of having the same problems reported.

Findings. A chi-square analysis was used to test the significance of the observed differences in frequency of repeated problems. Results are shown in Table 11.

Table 11

Comparison of Frequency of Repeated
Problems Identified in N/N, O/O and Control
Homes in 1979

TREATMENT CELL

	N/N	O/O
No repeat	208	150
Repeat	30	21

$$\chi^2 = .0094^*$$

	N/N	Control
No repeat	208	193
Repeat	30	14

$$\chi^2 = 4.2397^{**}$$

	O/O	Control
No repeat	150	193
Repeat	21	14

$$\chi^2 = 3.393^*$$

* Not significant at .05 level.

** Significant at .05 level.

Conclusions. Generally speaking, these findings suggest no difference between survey methods in their ability to reduce the frequency of repeated problems. In the rural districts, the difference in frequency of repeat problems between N/N and O/O homes was non-significant. In addition, the difference in frequency of repeat problems in O/O homes in the rural districts as compared to O/O homes in the Fond du Lac district was non-significant. However, surveyors report significantly more repeat problems in rural homes surveyed by the N/N method as compared to Fond du Lac homes surveyed by O/O method. This finding is difficult to interpret since it may be due to differences in the survey method, differences between districts, or to an interaction between survey method and district.

Study Number Four: Post-Monitoring of Citations Issued in the Rural Districts

Study Intent. For three years - April 1978 through March 1981 - the project tested its four treatment cells in the rural districts of La Crosse, Eau Claire, and Wisconsin Rapids. All homes in each of the districts were randomly assigned to the N/N, N/O, O/N, and O/O cells. In April 1981 the districts returned to the full survey and inspection.

From April 1981 through March 1982, QAP monitored the performance of the homes on the annual surveys following their participation in the project. As an indicator of quality of the homes, frequency and class of state violations and frequency of federal deficiencies were tabulated, and results were compared based on the homes' previous treatment cells. This comparison would provide an indicator of the relative status of QAP homes after three years of participation.

Findings. Post-monitoring results are shown in Table 12.

Table 12

Post-Monitoring of Citations, Issued
in the Rural Districts, April 1981 - March 1982

Previous QAP Treatment Cell	Class of Violation			Federal Deficiency Only	Total
	A	B	C		
N/N (28)	0	.2	6.8	1.5	8.5
N/O (30)	0	.2	6.5	1.4	8.2
O/N (30)	0	.1	6.9	1.3	8.3
O/O (32)	0	.3	6.9	1.6	8.8

A comparison of frequency of deficiencies/violations cited shows negligible differences between former treatment cells for any class of violation. No Class A violations were cited in any cell. Average number of Class B violations was small in all cells, ranging from .3 in O/O homes to .1 in O/N homes. Average number of Class C violations was essentially the same in all former cells, ranging from 6.5 in N/O homes to 6.9 in O/N and O/O homes. Average number of federal-only citations was also very similar between cells, ranging from 1.3 in O/N homes to 1.6 in O/O homes. As a result, homes in all former treatment cells averaged a total of approximately eight violations/deficiencies per home.

Conclusions. Using frequency of violations/deficiencies as a proxy measure for quality of care, it appears that there is no difference between homes based on their previous survey and inspection methods. Thus, homes that received QAP screening and sampling methods did not improve or deteriorate as compared to homes which received full survey and inspection of care.

Study Number Five: A Comparison of Elements, Standards and
Conditions Cited in New and Old Method Homes

Study Design. Wisconsin obtained approval from the federal government to waive certain rules and regulations which allowed surveyors to screen each nursing home using key indicators of quality of care. During screening surveyors were not expected to be looking at every code area. They focused instead on indicators directly related to resident care outcomes. If screening suggested a home was having problems in its care delivery system, then surveyors would look in-depth at the home's code compliance.

Because surveyors were not routinely looking at every federal code comprising the conditions of participation, it was predicted that QAP surveyors would cite fewer "paper-compliance" deficiencies not directly related to resident care but that they would cite as many serious deficiencies as old method surveyors. Two hypotheses resulted:

- (a) QAP surveyors will cite fewer federal elements than old method surveyors; and
- (b) QAP surveyors would cite equal number of federal standards and conditions which had a direct impact on patient care as compared to old method surveyors.

The conditions of participation are the most all inclusive level of requirements. They are areas of service that a facility must meet at least to the minimum level prescribed by federal regulations in order to be certified for federal funds. There are currently 18 conditions of participation, such as nursing services and pharmacy services. Standards are federal regulations which determine whether or not a facility meets minimal compliance with a condition. Elements are the component requirements under a standard which must be substantially met for the standard to be in compliance. Elements are the most discrete level of requirements.

Previous studies conducted by QAP had examined differences in frequency of state violations cited by level of severity (see Chapter II, Section D, Studies One and Two) but had not looked specifically at differences in severity of federal deficiencies. This study was undertaken to look solely at federal citations and to verify that QAP surveyors were finding as many serious federal problems.

A random sample of 60 homes was selected. Thirty homes were eligible for the N/N method and were drawn from the Madison, Green Bay, and Milwaukee districts. Thirty homes were from the O/O treatment cell and were drawn from the Milwaukee, Fond du Lac, La Crosse, Eau Claire, and Wisconsin Rapids districts. Results of annual surveys conducted between April 1981 and March 1982 formed the basis for the comparison.

Data collected in this study included both state violations and federal deficiencies. Total frequencies were based on total number of federal codes reported deficient. Total federal deficiencies were then sorted into elements, standards, and conditions and tallied by category.

Findings. Results are shown in Table 13.

Table 13

Average Number of Federal Elements, Standards
and Conditions Cited in N/N and O/O Method Homes

Survey Method	Federal Deficiencies		
	Elements	Standards	Conditions
N/N (30)	1.7	.2	0
O/O (30)	2.6	.2	0

As predicted, QAP surveyors cited fewer federal elements. They cited 1.7 per home as compared to 2.6 per home in old method homes. However, there were no differences in the numbers of standards and conditions cited in new and old method homes. Both QAP and old method surveyors averaged .2 standards and no conditions cited per home.

Conclusions. QAP surveyors used the option not to cite non-serious federal deficiencies. However, they detected and cited the more serious standards and conditions equally well as compared to old method surveyors. These results were in line with the predicted outcomes.

E. USE OF THE ADVISORY NURSING HOME ADMINISTRATOR--DESCRIPTION AND IMPLEMENTATION

One QAP innovation was the addition of the advisory nursing home administrator to the state survey team. These practicing administrators voluntarily served as advisors to the state team, particularly in the areas of management and philosophy. Certain criteria had to be met before an administrator could participate. The criteria specified that the advisory administrator must:

1. be endorsed by his or her association (if he or she is a member of a state nursing home association);
2. not have any enforcement action pending against his or her own facility;
3. attend a training session annually;
4. sign a participation agreement; and
5. be verified as being duly licensed and in good standing by the Nursing Home Administrator Examining Board (NHAEB).

Screening Procedures for Advisory Nursing Home Administrators

Once an administrator had been nominated by his or her association, had volunteered, or had been recommended by a surveyor, he or she was then required to attend a training session and sign a participation agreement (see Attachment 16).

QAP staff then reviewed the survey and inspection record of the advisory administrator's home. (It was advantageous to do a file check prior to training, but time constraints usually did not permit this earlier review.) The most recent survey was checked for number and class of violations/deficiencies. The number of complaints against a home was also checked, as well as the administrator's tenure at the home (see Attachments 17 and 18). If an administrator's home had an unacceptable performance record, approval was withheld until the problem was corrected or further study was completed.

A list of the candidates' names was submitted to the Nursing Home Administrator Examining Board. The NHAEB reviewed the licensure status of the names submitted, and they informed us if there were any complaints pending against an administrator on the list.

The three state nursing home associations were also contacted. They were asked to notify QAP if there were any administrators on the list whom they felt they could not recommend for project participation.

Upon completion of the screening process, a letter was sent to the administrators informing them of their acceptance and welcoming them into the project. They were then ready to be scheduled on a survey.

Continuing Education Credit

Since August 1978 the Nursing Home Administrator Examining Board approved ten continuing education credit hours for administrators who participated in QAP training and in two field experiences as advisors to the survey team. Because not all administrators completed the two field experiences, we requested approval to award partial credit. In November 1980 the NHAEB approved our request that two credit hours be given for one training session and four credit hours for each field experience.

We checked advisory administrators' participation records each quarter to determine those administrators who qualified for credits. We subsequently sent certificates for the credits to the advisory administrators and we notified the NHAEB.

Study Number One: A Summary of Frequency of Use of the Advisory Nursing Home Administrator

Table 14 reflects the percentage of homes eligible for a new screening assessment whose survey included an advisory nursing home administrator on the survey team. Total number of homes eligible to have an advisory administrator on the team are shown in parentheses, and this number includes homes eligible for facility screening which were switched to full survey. Data are reported for all QAP districts for 1979 through 1982. (Attachment 19 contains a monthly summary of participation.)

Table 14

Percentage of New Method Surveys Which
Included an Advisory Nursing Home
Administrator on the Survey Team

Year	District						Total
	1	2	4	5	6	7W	
1979	NA	93%(15)	NA	89%(18)	76%(33)	86%(14)	84%(80)
1980	93%(30)	65%(20)	86%(37)	59%(17)	65%(31)	21%(14)	71%(149)
1981	95%(40)	75%(20)	82%(51)	80%(5)	40%(5)	50%(6)	82%(127)
1/82 5/82	86%(14)	100%(4)	92%(24)	NA	NA	NA	90%(42)

The project has shown a consistent and frequent pattern of use of the advisory administrator. With the exception of calendar year 1980, 82% to 90% of eligible homes have had an advisory administrator team member. This pattern of use has been applied fairly consistently in all districts. (The lowest percentage of use was 50% in district 7W, Wisconsin Rapids, in 1981, and this result is at least partially due to the small number of homes included in this district in 1981.)

In 1980, use of the advisory administrator declined to a total of 71%. This decline was due to the fact that QAP had a shortage of trained advisory administrators and therefore scheduled them primarily in homes where surveyors indicated they were most needed. However, to fully test this component of QAP, our federal Project Officer requested that we attempt to use them in all eligible homes, and the project subsequently returned to this guideline.

QAP has been able to schedule an advisory administrator for most all eligible homes. The most common reason for not including an advisor was last-minute cancellation by the scheduled advisory

administrator. In winter months this cancellation was often due to bad weather. In spite of these cancellations, use of the advisory administrator was substantial.

Study Number Two: Attitudes Toward Use of the Advisory Nursing Home Administrator

In spring 1980 QAP conducted interviews with surveyors and advisory nursing home administrators (NHA's) regarding their attitudes toward the advisory administrator component. Two attitude questionnaires were developed and administered in an effort to gauge the outcome of this program. These attitude assessments were conducted between April and June 1980. In that three-month period, 27 surveyors and 29 advisory NHA's were interviewed.

Reaction of State Surveyors. Following each survey, the state coordinator for each survey team was contacted via telephone by a QAP staff member and asked to give his or her reactions to the addition of a particular administrator as an advisor to the survey team. Our initial data showed generally favorable response by surveyors to use of advisory administrators on surveys.

Q: Did you have any problems with this NHA?

R: No = 92% (25) Yes = 8% (2)

Q: Did the NHA communicate well with nursing home staff and members of the survey team?

R: No = 0 Yes = 92% (25) Don't Know = 8% (2)

Q: Would you want this NHA to join you on another survey?

R: No = 11% (3) Yes = 85% (23) Acceptable, but prefer another = 4% (1)

Advisory administrators who received strongly negative comments from surveyors were not scheduled for further surveys. Occasionally, some type of personality conflict was apparent between the NHA and the survey coordinator and then that administrator was scheduled elsewhere in the future.

Q: On which day of the survey would you prefer to have the NHA participate?

R: Day 1 = 33% (9) Day 2 = 30% (8) Either = 35% (10)

There was no overwhelming preference on the part of surveyors as to which day was more suitable for NHA participation. Our NHA scheduling coordinator reported a tendency for surveyors to support participation on the last day of survey. From their comments, it appeared surveyors found the last day generally preferable in problem homes because it was helpful to have the NHA participate in the meeting with the facility staff.

Q: In general, what do you believe is the major function of including an NHA on the survey team?

R: It was difficult to summarize this response, but a sample of some of the answers provides insight into surveyor's feelings about the use of the NHA. Several surveyors mentioned they felt the NHA lent more credibility to the survey team. Others felt the administrative experience of the NHA contributed to the process. Other responses were: demonstration of the state's interest in education as well as in enforcement, an additional viewpoint which offers practical solutions, and increased communication between the team and the nursing home's staff.

Not all feedback received from the field was positive. One surveyor in particular felt use of the NHA wastes surveyor time during the survey.

As these results indicate, surveyors were generally positive about including NHA's on the survey team. They reported few problems and desired to have the NHA return on future surveys. They felt the NHA lent credibility to the survey team and provided a valuable administrative perspective.

Reactions of Advisory Nursing Home Administrators. Following each survey, the participating advisory administrator was contacted via telephone by a QAP staff member and asked to give his or her reactions to the survey experience. Our investigation indicated an enthusiastic response on the part of administrators.

Q: On which day of the survey would you prefer to participate?

R: Day 1 = 14%(3) Day 2 = 67% (14) Either = 14% (3)
Both = 5% (1)

Most of the administrators indicated a preference for the last day because it enabled them to participate when the survey team presented its findings and recommendations to the staff.

Q: Was there enough time for you to assess the nursing home?

R: No = 17% (5) Yes = 83% (24)

Most of the administrators who felt there was not enough time said they were unable to cover all the items listed on the forms. Several recommended simplifying the forms for NHA use.

Q: What specific activities did you engage in during the survey?

R: <u>Activity</u>	<u>Frequency</u>
Talking with staff and residents	17
Review areas and procedures	16
Activities	5
Administrative policies	4
Dietary service	3
Fire safety plan	2
Nursing services	1
Personnel problems	1

Q: What skills or knowledge do you feel you were able to contribute to the survey of this home?

R: <u>Skills</u>	<u>Frequency</u>
Administrative management.....	20
General	14
Financial	3
Personnel	3
Liaison.....	3
Other Knowledge.....	5
Patient care	3
Activities	1
Physician orders	1

Q: Did you gain anything for yourself or your facility from your participation on the survey team?

R: No = 19% (4) Yes = 81% (17)

The four administrators who indicated that they did not gain anything from the survey said they found this a function of the particular home being surveyed as opposed to the survey process.

Q: How would you generally assess the role of the volunteer NHA on the survey team?

R: <u>Role</u>	<u>Frequency</u>
Advisory	9
Communication facilitators	5
Providing liaison between the team and the home	3

Providing a different perspective
on problems

3

As results from these attitude assessments indicate, advisory administrators who participated in QAP surveys generally found it a positive experience. They engaged in a wide variety of review activities and believed they could contribute successfully to a home's administrative management. They viewed themselves primarily as advisors and facilitators.

This study was originally published in the QAP Second Annual Report, 1979 - 1980.

F. SYSTEMS PROBLEMS--DESCRIPTION AND IMPLEMENTATION

The Quality Assurance Project has stressed that the overall nursing home system, from administration on down, be assessed for its impact on patient care rather than focus on separate discipline areas and individual code violations. In this framework, the facility is screened for ten key quality care areas. (Attachment 14 contains the QAP facility screening tool.) Surveyors based their decisions on the total "systems" perspective of the facility rather than on the discovery of an isolated occurrence.

The systems approach required communication between surveyors about findings, as seemingly minor problems might tie into a systems problem which crossed discipline lines. After tracing problems to a cause, problems were grouped into problem areas. One problem area might include many code violations and/or non code-related items.

Problems found were documented on a Summary of Findings (SOF) form (see Attachment 20). The form was laid out so that problem areas, which may cover more than one department in the home could be described. Each problem documented in the Findings column of the SOF form was to include the magnitude of the problem, the source, if known, at the time, and the impact of the problem on the resident(s). Each problem listed had to have a corresponding entry in the State Action column. In this column, the surveyor would indicate the action or actions he or she planned to take to follow up on the problem and the anticipated completion date.

Assessment of Implementation

In some cases, surveyors tied discipline areas together in their approach to problems identified in a facility, but overall, surveyors rarely discussed problems in-depth at the conference prior to their exit and usually filled out separate Summary of Findings forms. (QAP originally required surveyors to fill out the Summary of Findings form as a team, but changed its position after strong surveyor protest.) This resistance may have reflected an inability to identify and assess systems problems and strengths. For the most part there was a lack of systems and multidisciplinary problems identified.

G. SURVEYOR TIME REALLOCATION--DESCRIPTION AND IMPLEMENTATION

The QAP model was based on the premise that the State should allocate surveyor time so that more time is spent in homes having problems and less time in homes providing quality care. This reallocation enabled surveyors to more efficiently use available resources based on need rather than spending the same amount of time in each home irrespective of its quality.

Study Number One: Surveyor Time Reallocation by Quality of Home

Study Intent. The project's original hypotheses predicted that under the QAP methods, surveyor time would be allocated based on the quality of the home. Surveyors would spend less time on facility and resident review in good quality homes, and the "saved time" would be reallocated to poorer quality homes. This predicted outcome was in contrast to the old method which allocated the same amount of time to every home irrespective of its quality. It was further hypothesized that the average amount of total time spent on new method surveys would not vary greatly from the average total time spent on the old survey process. The QAP methods were intended to use the same amount of total time as the old method but to reallocate this time in a more effective and efficient manner.

A time study was developed to test these hypotheses using existing Bureau of Quality Compliance resources which included the computerized monthly time and activity reports for all employees and assistance from the Department's Office of Information Systems. The time study reported here is an expanded version of the study published in our 1980-1981 Third Annual Report.

This study compares N/N method surveys in the Madison and Green Bay districts and O/O surveys in the non-QAP districts of Fond du Lac, Rhinelander and part of Milwaukee. This design was chosen in part because of the reduced probability of surveyor overlap into both O/O and N/N surveys. Time reported by surveyors from other districts or by bureau consultants who assisted on any survey was also included. Engineer hours were excluded from the study.

The time period of the study covers annual surveys between June 1980 and April 1981 (excluding January 1981, for which accurate computer printouts were not available at the time of the study). Data from May 1980 were included to pick up resident review time where surveyors enter homes prior to their June survey. May and June 1981 activity reports also were included so that all follow-up activities for annual surveys near the end of the study period would be included.

Quality ratings were gathered for each home in the study. These ratings were derived from subjective surveyor ratings of each home and were obtained from the project's independent evaluators. They were updated by QAP and bureau staff to reflect recent changes in each home's status.

Findings. Results are summarized in Table 15 which shows the average number of hours spent per home by activity category in homes of varying quality under the N/N and O/O and survey methods.

A comparison of time spent in good homes suggests that QAP surveyors spend less time than old method surveyors in only two of eight activity categories. QAP surveyors spend less time on facility surveys (67.1 N/N vs. 80.8 O/O) and complaint investigation (4.3 N/N vs. 7.1 O/O). However, comparison of good homes under N/N and O/O methods is confounded by the large difference in average bed size, 107.5 beds in N/N homes and 144.8 beds in O/O homes. The net effect of this difference would be to reduce time spent in N/N homes based on size alone. In spite of the size difference, O/O surveyors still spend less time in the two categories of verification activities and consultation.

The comparison of time spent on resident review in good homes is complicated by differences in both home size and number of Medicaid residents. QAP sample size is determined by the home's total census, whereas old method workload is determined by total number of Medicaid residents. QAP and old method homes with a quality rating of good differ both on total census and number of Medicaid residents. In spite of the lack of comparability in number of residents, QAP surveyors spent only 3.6 fewer hours (61.1) than did old method surveyors (67.7) on resident review in homes that had 26% fewer total residents (107.55 in N/N homes and 144.8 in O/O homes) and 32% fewer Medicaid residents (52.6 in N/N homes and 77.5 in O/O homes). As a result, QAP surveyors spent proportionately more time on resident review in good homes than did old method surveyors.

On the remaining three activity categories--office work, surveillance, and legal activities, there was little or no difference between the methods on time spent in good homes. New method surveyors spent 1.7 hours on office work as compared to 2.5 hours by old method surveyors, a difference that could be due to home size alone. No time was spent on surveillance or legal activities by either method.

Both N/N and O/O method surveyors reallocate their time as quality of the home decreases. As quality declines, both methods increase the amount of time spent in each of the eight activity categories - facility survey, verification activities, complaint investigation, consultation, legal activities, office work, surveillance activities, and resident review. It should be noted that in N/N method homes, there is also an increase in average bed size from good to poor quality homes which would partially account for the corresponding increase in time. However, the average size difference does not appear large enough to refute the observed reallocation effect under the N/N method.

Table 15

A COMPARISON OF TIME ALLOCATION BY
QUALITY OF HOME FOR QAP AND NON-QAP SURVEYORS
IN 1980 AND 1981

-57-

Average Number of Hours Per Survey Activity (Home-Related)													
Survey Method/ Quality of Home	Facility Survey	Verification Activities	Complaint Investigation	Consultation/ Inservice	Legal Activities	Office Work	Surveillance Activities	Resident Review	Average Total Hours	# Homes	Average Bed Size	Average # Medicaid	
N/N Method													
Good	67.1	9.4	4.3	11.3	0	1.7	0	61.1	154.8	16	107.5	52.6	
Medium	73.3	9.2	5.4	11.3	1.3	1.8	.33	66.9	169.6	48	118.0	73.0	
Problem	94.1	15.4	13.5	24.8	13.3	5.3	12.9	73.4	252.6	7	121.4	74.6	
Overall N/N	73.9	9.9	5.9	12.6	1.5	2.2	2.1	66.2	174.4	71	116.0	68.5	
O/O Method													
Good	80.8	7.7	7.1	9.1	0	2.5	0	64.7	171.8	8	144.8	77.5	
Medium	83.1	7.4	1.3	9.0	1.4	1.8	.3	94.0	198.2	53	117.9	83.3	
Problem	94.2	23.6	50.0	15.7	2.3	8.9	2.3	135.4	332.2	8	114.5	86.4	
Overall O/O	84.1	9.3	7.6	9.8	1.3	2.7	.5	95.4	210.7	69	120.6	83.0	

The two methods differ in their respective patterns of reallocated activities. QAP surveyors show a larger reallocation of time to consultation/in-service (from 11.3 hours in good homes to 24.8 hours in poor homes), to legal activities (from 0 hours in good homes to 13.3 hours in poor homes), and to surveillance activities (from 0 hours in good homes to 12.9 hours in poor homes) than do O/O method surveyors. Old method surveyors show a larger reallocation of time to verification activities (from 7.7 in good homes to 23.6 hours in poor homes), to complaint investigation (from 7.1 hours in good homes to 50 hours in poor homes), and to resident review (from 64.7 hours in good homes to 135.4 hours in poor homes) than do N/N method surveyors. The difference in number of Medicaid residents in good and problem homes under the old method does not negate the finding of surveyor time reallocation. Although number of Medicaid residents increased 11% (from 77.5 to 86.4), the number of hours allocated increased 109% (from 64.7 to 135.4).

When average total time is compared by survey method, two significant trends become apparent. First, O/O method surveyors show a greater reallocation of time by quality of home than do QAP surveyors. Old method surveyors spend 171.8 average total hours in good homes and 332.2 hours in poor homes, an increase of 93%. This increase in time is particularly striking in old method homes since the average bed size drops from 144.8 beds in the good homes to 114.5 beds in poor homes; and smaller homes would typically require less total time. In contrast, QAP surveyors spend an average of 154.8 total hours in good homes and 252.6 total hours in poor homes, an increase of 63%.

Second, QAP surveyors spend less total time than O/O method surveyors. They spend less total time in homes in each of the quality categories, and they spend less total time across all quality categories than do O/O method surveyors. A comparison of total survey hours per home under N/N and O/O methods shows that N/N surveyors spend 36.3 fewer total hours per home than do old method surveyors (174.4 hours N/N vs. 210.7 hours O/O). Therefore, QAP surveyors are not reallocating all of the time saved.

In order to compare time spent on the more general categories of annual visits and follow-up activities, data in Table 15 were combined to reflect total hours spent on annual visits, interim visits, and office work. By collapsing the data in this fashion, we can more easily distinguish annual and follow-up activities.

Annual visits include time spent on the annual facility survey and resident review. Interim visits include verification activities, complaint investigation, consultation, and surveillance. Office time includes home-specific office time and legal activities. Hours in each of the three categories are also converted to percentages of total hours. The resulting total hours and relative percentages are shown in Table 16.

Table 16

A Comparison of Average Total Time
Spent on Annual Visits, Interim Visits and
Office Activities* in Different Quality Homes

Activity	Method	Quality of Home		
		Good	Medium	Poor
Annual Visit	New	128.2 (82.8%)	140.2 (82.7%)	167.5 (66.3%)
	Old	145.5 (84.7%)	177.1 (89.4%)	229.6 (69.1%)
Interim Visits	New	25 (16.1%)	26.2 (15.5%)	66.6 (26.4%)
	Old	23.9 (13.9%)	18 (9.1%)	91.6 (27.6%)
Home-Related Office Work	New	1.7 (1.1%)	3.1 (1.8%)	18.6 (7.3%)
	Old	2.5 (1.4%)	3.2 (1.5%)	11.2 (3.3%)
Total	New	154.8 (100%)	169.6 (100%)	252.6 (100%)
	Old	171.8 (100%)	198.2 (100%)	332.2 (100%)

*Based on Bureau of Quality Compliance Monthly Surveyor Activity Reports.

A comparison of time allocation in good homes under the two methods shows that, as hypothesized, QAP surveyors spend less time on annual visits and on office work than old method surveyors. QAP surveyors spend 128.2 hours on annual survey as compared to 145.5 hours by old method surveyors. They spend 1.7 hours on office work vs. 2.5 hours by old method surveyors. However, contrary to expectations, they spend somewhat more time on interim visits in good homes. QAP surveyors spend 25 hours on interim visits in contrast to 23.9 hours by old method surveyors.

A comparison of amount of time spent as quality of the home decreases reaffirms the earlier unanticipated conclusion that both methods reallocate their time based on quality. As quality deteriorates, both N/N and O/O method surveyors increase the amount of time spent on annual visits, interim visits, and office work. On annual visits, QAP surveyors spend 128.2 hours in good homes and 167.5 hours in poor homes; O/O method surveyors spend 145.5 hours in good homes and 229.6 hours in poor homes. On interim visits, QAP surveyors spend 25 hours in good homes and 66.6 hours in poor homes; old method surveyors spend 23.9 hours in good homes and 91.6 hours in poor homes. On office work, QAP surveyors spend 1.7 hours in good homes and 18.6 hours in poor homes; O/O method surveyors spend 2.5 hours in good homes and 11.2 hours in poor homes.

Thus, as the above figures show, O/O method surveyors demonstrate greater time reallocation by quality of home than QAP surveyors. They show greater increases in time spent on annual visits and on interim visits as quality deteriorates. In contrast, QAP surveyors show a relatively greater increase in time spent on office work than O/O method surveyors.

Table 16 also shows the relative proportion of time spent by quality of home under the two methods. A comparison of percentages gives a somewhat different perspective. This comparison also enables us to contrast results of the QAP study with findings from the surveyor time reallocation study conducted by WHCRI. Results of the WHCRI study were reported only in percent of time spent in the three activity categories by quality of home and survey method.

QAP surveyors show a proportional reallocation of time as quality of the home decreases. As quality deteriorates, QAP surveyors spent proportionately less time on annual visits, even though the actual number of hours goes up, (82.8% in good homes to 66.3% in poor homes) and proportionately more time on interim visits (16.1% in good homes to 26.4% in poor homes). They also increase the relative proportion of time spent on home-related office work (1.1% in good homes to 7.3% in poor homes). However, irrespective of the quality of the home, annual visits use the largest proportion of time.

A similar comparison of proportional time allocation by quality of home under the old method shows a pattern very similar to that of the new method and the respective size of percentages is also similar. As quality of the home decreases, old method surveyors spent proportionately less time on annual visits, even though actual number of hours increase (84.7% in good homes to 69.1% in poor homes) and more time on interim visits (13.9% in good homes and 27.6% in poor homes). They also increase the relative proportion of time spent on home-related office work (1.4% in good homes and 3.3% in poor homes). However, irrespective of the quality of the home, annual visits constitute the largest proportion of time.

Conclusions. Results of the QAP study lend support to the following conclusions:

1. The hypothesis that QAP surveyors would spend less time in good homes than old method surveyors is partially met. In good homes, QAP surveyors spend less time on facility survey and complaint investigation than old method surveyors. However, QAP surveyors spend more time on interim visits in good homes than O/O method surveyors, specifically on verification activities and consultation/in-service. They also spend proportionately more time on resident review in good homes as do old method surveyors.
2. The hypothesis that QAP surveyors would spend more time in poor quality homes than old method surveyors was not met. In poor quality homes, QAP surveyors spent more time only on

consultation/in-service, legal activities, and surveillance. However, old method surveyors spent more time on verification activities, office work, and resident review and more time overall.

3. The hypothesis that QAP surveyors would reallocate their time based on quality of the home was met. This reallocation was observed in all activity categories. However, old method surveyors demonstrated an even greater reallocation of time based on quality of the home than did QAP surveyors.
4. The hypothesis that QAP surveyors would spend the same average total time in a home as old method surveyors was not met. QAP surveyors spend less time in homes overall as well as less total time in homes in each of the quality categories. Thus, QAP surveyors are spending less time rather than reallocating this time savings. QAP surveyors reduced total time by 17% as compared to old method surveyors.

H. ALTERNATE ACTIONS--DESCRIPTION AND IMPLEMENTATION

As an integral part of the time reallocation process, QAP methods stressed use of a wider range of follow-up actions when problems were found as compared to the old method. In addition to citing, surveyors could consult, investigate further, conduct a surprise or full survey, review more residents or do an inspection of care, make informal recommendations, or take no further action beyond screening and sampling. They could also request that a special advisor accompany them on the survey to provide expertise in a given area. In addition, when a home was complying but had a quality problem (e.g., had an advisory dentist who did not contribute to the quality of resident care), the State could work with the facility staff to correct this quality problem through the range of actions allowed.

Once the observation and investigation portions of the survey had been completed, the survey team chose which action or group of actions would be most appropriate to resolve the problems found. The following guidelines were to be considered when choosing the most appropriate action:

1. The home's previous history of change.
2. The evidence that correction will be made.
3. The home's response to the problem.

Listed below are actions that could have resulted from either the screening survey or resident sampling process.

1. Recommendations/Counseling

This action could be chosen for those homes in compliance with the codes but which may benefit from recommendations to improve the quality of ongoing systems. Any formal recommendations to the facility were to be documented on the Summary of Findings form. Informal counseling could be given at the time of the screening survey. No follow-up was necessary.

2. Investigate Further

During the screening survey, team members might identify potential problems in a facility but need additional information before they decide on further action. The survey team member(s) could request a special advisor as a consultant, or could use the full survey or any portion of it at this time. Results of the investigation were recorded on a Summary of Findings form.

3. Consultation/Inservice

Consultation/inservice was intended to help the nursing home correct a problem on its own by providing information in a particular problem area, e.g., nursing care plans. Consultation could not be used to impose solutions to problems on a home but was used to provide enough information so a home can select a solution which best suits its needs and resources.

A surveyor could provide the consultation or refer another consultant from the Bureau. The surveyor was to make every effort to be at the home during consultation and was responsible for conducting a verification visit to determine the home's action following the consultation.

4. Special Advisor

Surveyors could call in a special advisor to help in the initial screening survey/resident assessment or to help in further investigation of a particular area. The special advisor also advised team members when they were deciding what state actions should be taken.

5. Citations

Any federal deficiencies or state code violations to be cited were recorded on a Notice of Violation. See Chapter II, Section D, "Screening for Quality", for a discussion of QAP citing procedures.

6. Partial Survey

When, during screening, an area was found to have serious problems, the surveyor was to return and check the entire area for code violations, using the Bureau's code checklist, the Single Survey Instrument (SSI).

7. Full Survey

When the facility was determined to warrant a full survey, either before or after the screening, then the complete code checklist was used.

8. Surprise Survey

One or more surveyors might choose to conduct surprise surveys at any time during the year. Surveyors could cover any area(s). They used a Summary of Findings form to document the results of the survey.

9. No Action

The screening survey/resident assessment findings might indicate there was no need for further action at the time.

The following were additional actions which might follow the resident assessment process:

1. Reevaluation Submission

When a surveyor discovered incorrect levels of care during the resident assessment process and the number of wrong levels did not require an inspection of care or second sample, the resident assessment coordinator asked the facility to submit a new evaluation of the resident's needs and level of care within 30 days. Homes which did not follow through would be eligible for an inspection of care.

2. Second Sample for Care Delivery

When further investigation was needed to add to their knowledge of the quality of the home's care delivery system, the resident assessment team was to review more residents. The QAP resident assessment forms were used to record findings.

3. Inspection of Care

When a home "flunked" the sample, an inspection of care was to be scheduled.

QAP emphasized the importance of timely follow-up actions particularly if potentially serious problems were discovered during the initial screening/sampling. For problems identified as having direct impact on resident care, follow-up was to be completed within 30 days of the survey exit date. For problems identified as having an indirect impact on resident care, follow-up was to be completed within 60 days. Follow-up dates could be extended to 90 or 120 days for problems requiring extended correction time. A benchmark date of 60 days was established and either onsite or telephone contact was made to verify that the facility was in the process of correcting.

Study Number One: Surveyor Use of Surprise Surveys

Study Intent. Under QAP guidelines, surveyors were encouraged to conduct surprise surveys in homes where resident care problems had been found during the annual survey. Surprise surveys could also be conducted if there is a change in the status of the home or in response to a complaint. Surprise surveys were used in any home eligible for one or more new treatment methods and conducted by one or more survey team members. The parallel form of non-annual survey under the old method was the interim survey which was typically conducted to investigate complaints.

As a part of routine monitoring, QAP staff tabulated number of surprise and interim surveys conducted in homes eligible for the new methods and in homes assigned to the old methods. A comparison of results enabled the project to assess whether QAP surveyors were conducting more surprise/interim surveys than were non-QAP surveyors.

Findings. Table 17 shows the percent of homes receiving surprise or interim surveys in QAP districts during calendar years 1980 and 1981. Results are separated by district and treatment cell. No results are shown for the rural districts for 1981 since these districts participated in the project for only three months in 1981, and the resulting small numbers of homes in the individual cells do not represent any meaningful trends. The number shown in parentheses is the number of homes in the treatment cell during the specified time period.

Table 17

Percentage of Homes Receiving Surprise/Interim
Surveys in QAP Districts in 1980 and 1981

District/Cell	Year	
	1980	1981
Madison	N/N 42% (26)	42% (38)
	O/N 32% (31)	29% (31)

Milwaukee	N/N	50% (20)	35% (20)
	O/O	26% (19)	53% (19)
	Control	32% (25)	16% (25)
Green Bay	N/N	42% (38)	22% (50)
La Crosse	N/N	40% (5)	
	N/O	17% (6)	
	O/N	50% (6)	
	O/O	50% (4)	
Eau Claire	N/N	31% (16)	
	N/O	71% (17)	
	O/N	40% (15)	
	O/O	13% (15)	
Wisconsin Rapids	N/N	80% (5)	
	N/O	100% (5)	
	O/N	14% (7)	
	O/O	13% (8)	

Results are mixed and vary both by district and by year. In the Madison, Milwaukee, Eau Claire and Wisconsin Rapids districts, QAP surveyors tended to conduct more surprise/interim surveys during 1980 than did non-QAP surveyors. In the Madison district, 42% of the N/N homes received a surprise/interim survey versus 32% of the O/N homes. In district 2, 50% of the N/N homes received surprise/interim surveys versus 26% in O/O homes and 32% in control homes. In the Eau Claire district, surprise/interim surveys in all new method cells (N/N - 31%; N/O - 71%; O/N - 40%) exceeded the surprise/interim surveys conducted in O/O homes (13%). In the Wisconsin Rapids district, surprise/interim surveys in all new method cells (N/N - 80%; N/O - 100%; O/N - 14%) exceeded the surprise/interim surveys conducted in the O/O homes (13%). However, in the La Crosse district, 50% of the homes in the O/O and O/N treatment cells received surprise/interim surveys versus 40% of the N/N homes and 17% of the N/O homes.

In 1981, QAP surveyors showed a relative decrease in surprise/interim surveys. In the Milwaukee district, 53% of the O/O homes received surprise/interim surveys versus 35% of the N/N homes. In the Green Bay district, percent of surprise/interim surveys dropped from 42% in 1980 to 22% in 1981. However, in the Madison district, N/N homes continued to receive more surprise/interim visits (42%) than did O/N homes (29%).

Conclusions. QAP surveyors tended to conduct more surprise/interim surveys than non-QAP surveyors. However, this trend was not pronounced and tended to vary both by district and by year. In 1980, QAP surveyors clearly conducted more surprise/interim surveys than non-QAP surveyors in all districts except La Crosse. In 1981, use of surprise/interim surveys declined somewhat in QAP homes, and of the two districts tallied, only Madison district surveyors were conducting more surprise/interim surveys in QAP homes as compared to non-QAP homes.

Study Number Two: A Summary of Follow-Up Actions Conducted in New and Old Method Homes in Years One Through Three

Study Intent. As a part of routine monitoring, QAP staff have tabulated the number and type of follow-up actions conducted by QAP and non-QAP surveyors. This monitoring enabled us to assess whether QAP methods were being implemented as proposed. We monitored whether QAP surveyors were conducting more follow-up visits in new method homes and what types of actions were being conducted.

Over time the data collection procedures were modified somewhat. During the first project year, counts of advice giving and counseling by surveyors during the survey were included as follow-up actions. These counts were discontinued after the first year since such counseling was often informal. In addition, during the first project year, we did not include counts of verification visits conducted to verify correction of a violation. Subsequently, we decided to include verification visits because they were clearly a follow-up action even though they were not a QAP innovation. These changes in counting procedures limit comparisons of findings between years.

Findings. QAP staff focused their monitoring activities on each district as it started up and conducted a minimum of one year of monitoring. We did not have enough personnel to collect all types of monitoring data in all districts for the full duration of project activities. Table 18 summarizes follow-up monitoring data reported in our three annual reports (1978-79, 1979-80, and 1980-81).

Table 18

Summary of Follow-Up Actions Conducted by
QAP Surveyors in Project Years One Through Three

Average Number of Follow-Up Actions Per Home						
District/Year/ Treatment Cell	Consult- ation/ Inservice	Special Advisor	Invest- igate Further	Return to Verify Problem Correction	Deficiency Verification Visit	Total
Rural Districts						
Year One (1978-79)						
N/N	3.2	.2	.6	.4	-	4.4
O/O	1.1	.1	0	0	-	1.2
Year Two (1979-80)						
N/N	1.5	.2	.4	.9	2.2	5.2
O/O	1.2	0	0	0	2.6	3.8
Milwaukee District						
Year One (1979-80)						
N/N	1.2	.1	.1	3.2	1.8	6.4
O/O	.9	0	0	0	4.1	5.0
Control	.3	0	0	0	3.2	3.5

Madison District

Year One (1980-81)

N/N	1.0	0	.1	2.7	.8	4.5
O/N	.4	0	.1	.4	1.5	2.4

Green Bay District

Year One (1980-81)

N/N	.5	0	0	1.9	.9	3.4
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Data in Table 18 indicate that QAP surveyors were conducting more follow-up actions than old method surveyors. The rural, Milwaukee, and Madison districts all contained both the new facility screening and old full survey methods, and in all of these districts, QAP surveyors conducted more total actions per home.

The actions most frequently conducted by QAP surveyors were consultation/in-service and verification activities (return to verify problem correction and verification visits for violations issued). Relatively little use was made of special advisors. With the exception of the first year in the rural districts, relatively little use was made of further investigation. As QAP moved into the expansion districts of Green Bay and Madison, verification activities became the most predominant follow-up action.

Conclusions. In the demonstration districts tallied, QAP surveyors conducted more follow-up actions per home than did non-QAP surveyors. QAP surveyors relied primarily on consultation/in-service and verification activities, i.e., return to verify problem correction and verification visits to determine correction of deficiencies cited.

Although QAP surveyors were conducting more total actions per home than old method surveyors, these actions tended to be traditional in nature and relatively little use was made of the more innovative QAP actions, such as further investigation.

Study Number Three: A Comparison of Surveyor Use of Follow-Up Actions Before and After the Change in QAP Citing Policy

Study Intent. The purpose of the study was to monitor the impact of the change in QAP citing policy on surveyor use of alternate follow-up actions. From the outset, QAP encouraged surveyors to use a wider range of actions above and beyond citing to correct problems and improve quality of care. Actions were to be based on the total systems perspective, and selection of corrective measures were matched to the problem. However, on October 1, 1981, QAP came into conformance with the bureau policy which required citing of all violations of state codes.

Although QAP did not change its guidelines on use of alternate actions, we anticipated that their use might be affected by the change in citing state codes. We were concerned that the change might reduce the number of alternate actions conducted by surveyors. Although alternate actions could still be used on both code violations and non-code problems, they could no longer substitute for issuing violations of non-serious state Class C codes. In the latter case, alternate actions might be undertaken in addition to citing.

To measure the effect of the change in policy, we tabulated number and type of follow-up actions taken in the six months prior to the change (April-September 1981) as compared to the first five months after the change (October 1981 - February 1982). (No data were available for March 1982 at the time of preparation of this report.) Results were collected from all QAP districts - Green Bay, Madison, and Milwaukee.

Findings. Results from the expansion districts are shown in Table 19.

Table 19

Use of Surveyor Follow-Up Actions in the Expansion Districts Before and After the Change in QAP Citing Policy

AVERAGE NUMBER OF ACTIONS PER HOME						
Dist./Treatment Cell/Time Period	Number of Homes	Consult-ation Inservice	Special Advisor	Invest-igate Further	Return to Verify Problem Correction	Deficiency Verification Visit
Green Bay-N/N						
4/81-9/81	26	.4	0	0	1.5	1.4
vs.						
10/81-2/82	25	.3	0	0	1.3	1.8
Madison-N/N						
4/81-9/81	18	.4	0	0	2.8	1.6
vs.						
10/81-2/82	16	0	0	0	0	2.6
Madison-O/N						
O/N 4/81-9/81	19	.2	0	0	.2	1.9
vs.						
O/O 10/81-2/82	16	.3	0	0	0	2.1

The period of April through September 1981 constitutes the first half of the second year of operation in the expansion districts, and results from this time period can be compared to first-year findings shown in Table 18. In the Green Bay district, there was

little change. Verification activities continued to be most common, 1.9 return to verify per home and .9 verification visits per home in the first year as compared to 1.5 return to verify and 1.4 verification visits in the first six months of the second year. No use was made of special advisors or investigate further during either year. Minimal use was made of consultation, .4 per home in the first year and .3 during the first six months of the second year. The total number of actions remained unchanged, 3.4 actions per home during the first year as compared to 3.3 during the first six months of the second year.

When the revised citing policy took effect on October 1, there was little change in use of alternate actions by Green Bay surveyors. The pattern of reliance on verification activities continued; surveyors conducted 1.3 return to verify and 1.8 verification visits per home. Surveyors continued to make little use of consultation and no use of special advisors and investigate further. The total number of actions per home, 3.4, remained virtually unchanged.

In N/N homes in the Madison district, a comparison of first year findings (Table 18) to the first six months of the second year (April-September 1981) shows a pattern similar to that observed in the Green Bay district. Verification activities continued to be the most frequent activities. Madison surveyors conducted 2.7 return to verify per home in their first year and 2.8 during the first half of their second year. They conducted .8 verification visits during their first year and 1.6 during the first half of their second year. Consultation showed a small decline, from 1 per home to .4. No use was made of special advisors or investigate further during either time period.

In the Madison district, the change in QAP citing policy was accompanied by a change in use of alternate actions. All actions except verification visits were discontinued. Average number of verification visits per home rose from 1.6 to 2.6. The net effect was a decline in total number of actions taken, dropping from 4.8 to 2.6 per home.

In the Madison district, data were also collected for O/N homes which returned to the O/O treatment cell on October 1, 1981. These homes constitute a "control group" since follow-up actions are typically associated with the facility survey, and these homes received the old facility survey method for the duration of the data collection period. A comparison of old and new method homes in the Madison district reveals two key findings. First, before the change in QAP citing policy, N/N surveyors were conducting more total actions per home (4.8) than were O/N surveyors (2.3). Second, after the change in citing policy, the pattern and frequency of use of alternate actions by N/N surveyors changed to match that of O/O surveyors. Total number of actions conducted were similar, 2.6 per N/N home and 2.4 per O/O home. In addition, both methods were relying on verification visits, 2.6 per N/N home and 2.1 per O/O home. Few consultations were conducted by O/O surveyors (.3), but none were conducted by N/N surveyors.

A comparison of O/N homes in the first six months to O/O homes in the subsequent five months shows little or no change in pattern of use or frequency of use of follow-up actions. This outcome is in line with our expectations since there were no changes in policy which would affect use of follow-up actions in the homes.

Table 20

Use of Surveyor Follow-Up Actions in the Milwaukee District Before and After the Change in QAP Citing Policy

AVERAGE NUMBER OF ACTIONS PER HOME						
Dist./Treatment Cell/Time Period	Number of Homes	Consultation Inservice	Special Advisor	Investigate Further	Return to Verify Problem Correction	Deficiency Verification Visit
N/N						
4/81-9/81	10	0	0	.7	1.6	.8
vs.						
10/81-2/82	8	0	0	0	1.8	1.5
O/O						
4/81-9/81	11	0	0	0	0	2.2
vs.						
10/81-2/82	9	0	0	0	0	1.6
Control						
4/81-9/81	11	0	0	0	0	2.4
vs.						
10/81-2/82	10	0	0	0	0	2.2

Equivalent findings from the Milwaukee district are shown in Table 20. The period of April through September 1981 constitutes the first half of the third year of operation in the Milwaukee district, and results from this time period can be compared to first-year findings shown in Table 18. With the exception of investigate further, there was a decline in frequency of use of all other actions. N/N surveyors showed a small increase in use of investigate further, from .1 per home to .7. However, use of consultation/inservice dropped from 1.2 per home to zero. Special advisors dropped from .1 to zero. Return to verify problem correction dropped from 3.2 per home to 1.6. Verification visits dropped from 1.8 per home to .8. As a result, total actions conducted per home decreased 50%, from 6.4 to 3.1.

When QAP implemented the change in citing policy, the pattern and frequency of use of alternate actions remained relatively unchanged in N/N homes. Surveyors continued to omit any use of consultation/in-service or special advisors. Use of investigate further dropped from .7 per home to zero. Use of return to verify remained stable, from 1.6 to 1.8 per home. Use of verification visits showed a small increase, from .8 to 1.5 per home. The net effect was little change in total use of actions, from 3.1 per home to 3.3.

A comparison of N/N homes to O/O and control homes reveals both differences and similarities. First, although QAP surveyors were relying on the traditional verification activities, they were still consistently conducting somewhat more total follow-up actions per home than old method surveyors. During April-September 1981, QAP surveyors conducted 3.1 actions per home vs. 2.2 per home in O/O homes and 2.4 per home in control homes. During October 1981 through March 1982, QAP surveyors conducted a total of 3.3 actions per home vs. 1.6 in O/O homes and 2.2 in control homes.

However, surveyors in all treatment cells relied primarily on verification actions. In O/O and control homes, the only follow-up actions conducted were verification visits and frequency of use of these visits remained relatively stable. In O/O homes, surveyors averaged 2.2 and 1.6 visits per home during the two time periods. In control homes, surveyors averaged 2.4 and 2.2 visits per home in the two time periods. QAP surveyors also relied on verification visits and return to verify during the two time periods.

Conclusions. QAP monitored frequency and type of follow-up actions used by surveyors before and after the change in QAP citing policy. Although there was no change in QAP guidelines regarding use of follow-up actions, it was anticipated that the change in citing policy might nonetheless affect use of alternate actions.

Our findings confirmed that the change in citing policy was accompanied by some changes in surveyor use of follow-up actions. However, these changes were extensions of trends that had already been developing in new method homes.

1. In one of the three districts, there was a decline in use of follow-up actions in N/N homes which occurred concurrently with the change in citing policy. Madison surveyors used fewer total actions per home while Green Bay and Milwaukee surveyors showed no change.
2. When compared to old method surveyors, N/N surveyors were conducting more actions per home in the Madison and Milwaukee districts prior to the change in citing policy. After the change, N/N surveyors in Milwaukee continued to conduct more total actions than old method surveyors, while number of actions conducted by N/N surveyors in the Madison district declined to the same level as O/O surveyors. (There was no O/O comparison group within the Green Bay district.)

3. Prior to the change in citing policy, data on use of follow-up actions indicated that over time QAP surveyors were increasingly relying on verification activities. Use of alternate actions such as consultation, inservice, and investigate further were declining, and in some cases had dropped to zero. The change in citing policy only intensified this pre-existing trend. Use of alternate actions dropped even more, and in N/N homes in the Madison district, surveyors discontinued all actions except verification visits.

Thus, by the end of the demonstration, use of alternate actions was being minimally implemented by QAP surveyors. Although there was some evidence that QAP surveyors were conducting more total actions per home than old method surveyors, they were making an increasing and primary reliance on traditional verification activities.

CHAPTER III

ADMINISTRATIVE COMPONENTS

There were four fronts of activity in carrying out the demonstration project: (1) researching the federal approval process, which included identifying regulations we needed waived, developing experimental design and evaluation methods, and clarifying the role of federal staff at the regional and national levels; (2) gaining a base of support in the Wisconsin Governor's Office, Legislature and among our congressional delegates; (3) procedure development and training of surveyors in project methods; and (4) obtaining interest and support from field staff, the nursing home industry and consumer interest groups who would be involved.

In this chapter we discuss the major administrative activities which were necessary to obtain project approval and maintain project operation. One important ongoing task was ascertaining and meeting the federal requirements for project operation. We were in contact with federal officers regarding pre-waiver inspections, the Advisory Panel, approval to screen for the Life Safety Codes, consumer group participation, Medicare approval, and federal validation surveys.

Another major aspect of operation was administration of the project itself. In this chapter, we also describe the project's organization, staffing, and liaison with other agencies.

A. FEDERAL REQUIREMENTS AND APPROVAL

Chronology

Although Wisconsin had been discussing the concept of a demonstration project for almost one year, it was not until November of 1977 that formal contact was made with staff of the then U.S. Department of Health, Education and Welfare (now the Department of Health and Human Services) to learn how to obtain approval to carry out a demonstration of screening and sampling to assess quality of nursing home care. The complexity of the federal review and approval process became apparent between receipt of the Section 1115 Waiver Application Packet in December 1977 and our initial approval in July 1978.

Pre-Approval Period. With assistance from staff at the University of Wisconsin, we compiled a proposal following the format prescribed in the Section 1115 waiver packet. (The authority for HHS to approve demonstrations is granted in Section 1115 of the Social Security Act, hence the reference.) The proposal said what we intended to do, who would do the work, and how much money it would cost. In January 1978 we discussed this proposal in person with federal Region V survey and certification staff, and sent our original and six copies to the designated federal Grants Office in Washington, D.C.

Problems and questions about the proposal had already surfaced at Region V, and we were unsure whether answers existed. For example, it was unclear whether we could obtain approval to carry out the demonstration in Medicare facilities. It was also important to the Region that we supply them with "crucial data" and certain facility waiver items, for which they had oversight responsibility. In the end, there were thirty questions about the project for which the Region requested a response.

Not until April, when approval seemed imminent, did contacts with the Grants Office in Washington, D.C. heighten. We were asked for additional documentation on the role of the engineer and, in the end, submitted three different budget workups.

Meanwhile, due to unforeseen delays at the federal level, our timeline for implementation was over-taking the federal approval process. In May, formal waiver approval was uppermost in our minds, as the demonstration was fully underway at our initial demonstration site (see Chapter III, Section A, "Pre-Waiver Inspections"). We sent further documentation on the proposed evaluation tool to assess quality of care, and another budget amendment reflecting the effect of the demonstration on potential nursing home reimbursement disallowance as provided under Section 1903(g) of the Social Security Act. Also, in May, it became clear that before approval could be granted, we would have to obtain an institutional review board determination on protection of human subjects. In discussions with the Grants Office, we kept attempting to pinpoint (1) which regulations actually needed to be waived; (2) which budget (among the many we had submitted) was the "real" budget; (3) whether we could screen in Medicare homes; and (4) whether we would receive any funding to carry out the demonstration.

Since we had submitted our proposal spontaneously (rather than in response to a federal solicitation announcement), it became clear that the likelihood of obtaining any funding was remote. Therefore, when a request for proposals appeared in the May 1978 issue of the Federal Register, we began to prepare a grant application for funding in which we proposed to study regulatory issues underlying the demonstration. We also administered pre-tests in the rural districts, since our responsibility for evaluating the demonstration was still not clear (see Chapter III, Section B, "Liaison with Independent Evaluators").

In June we learned that our demonstration approval as a waiver-only project might be delayed as late as July 1, 1978. We submitted the human subjects review report and fulfilled other requests for additional information. As the decision date neared, we also were forewarned that approval for Life Safety Code screening would not be forthcoming (see Chapter III, Section A, "Life Safety Code Approval"). To obtain funding that would enable us to evaluate the project's effectiveness, the separate grant proposal was completed and submitted for review.

Year One. In July, we received our letter of approval, effective 7/1/78 through 6/30/79. There were conditions attached to that approval. Responding to those conditions and seeking approval to continue were our primary objectives during "year one". We were assigned a Project Officer in our approval letter, since the Grants Officer handled only the initial review and fiscal monitoring. Almost immediately we were assigned an interim Project Officer while our Project Officer was on a one-year leave.

Understanding the terms of our approval and responding to the approval conditions were immediate priorities. It became clear to us that we would receive no grant monies other than the normal federal match for our survey and project administration staff. We also were not successful in obtaining approval to screen for Life Safety Codes or to screen in Medicare facilities.

The nine conditions for approval required us to add gerontological expertise to the project staff and implement the project methods in an urban setting; produce an "evaluation plan", although this was later modified such that HCFA would, with our assistance, prepare a request for proposals (RFP) for contracting with an independent evaluator; submit several types of additional information; clarify the project's organizational lines of reporting; and routinely submit quarterly reports to HCFA. (See Attachment 21 for a complete listing of all previously published reports of the Quality Assurance Project.)

Project, Region V and central office HCFA staff met in Washington, D.C. in August 1978 to facilitate development of new lines of paper flow and communication. Among other issues, we had to come to some agreement with the Region on the homes which had been screened and sampled prior to July 1, when federal approval was officially granted. We also had to develop new procedures for reporting to the Region.

Another major goal of the first year was to obtain approval to continue the demonstration for a second year. We submitted a continuation proposal in March 1979, again following the format and institutional review board approval requirements specified in the Section 1115 waiver application packet. It was also necessary to submit an addendum to our continuation application to cover four changes or areas needing further explanation. First, we again had to research which regulations we needed waived, since federal regulations had been renumbered and rewritten since our initial approval. Second, we detailed the proposed expansion into additional survey districts in the state, clarifying our original definition of "statewide." Third, we updated our budget to reflect our revised plan for expansion. Finally, we included additional letters of support for the project, the required institutional review board documentation, and errata. We asked to be considered for funding; however, we did not make our approval request contingent on a grant award.

In the course of the review for second year approval, the regional office brought up several problems relating to the project. First, due to a breakdown in state and regional communications, a new method home which had applied for Medicare certification was inadvertently screened. Four months later the Region ordered surveyors to return and do a full survey. We took the opportunity to compare the findings of the old and new method surveys. Secondly, while endorsing continuation, the Region again raised a list of concerns about the project which they wished resolved before second year approval was granted. Our Project Officer asked that we respond fully to each issue raised, and we began work on this effort. Finally, having reviewed the proposed new role for the engineer, as elaborated in our continuation proposal, the Region requested more detailed procedures for screening for Life Safety Codes and for paper flow to the Region. Although we ended the project's first year without written approval to continue for a second year, that approval was awarded shortly thereafter, effective July 1, 1979-June 30, 1980.

Year Two. Included in our second year approval were two approvals not granted in year one: screening for Life Safety Codes (pending further review of the engineer/architect role by the regional office) and expanding operations into the Green Bay and Madison districts. We were again unable to obtain approval to perform screening surveys in Medicare certified nursing homes. Other than the requirement to continue to submit Quarterly Reports to HCFA, there were no formal conditions attached to our second year approval, and no mention of an evaluation.

With project continuation affirmed, we returned to researching and responding to questions Region V had raised about the project's procedures, financial reporting, and Life Safety Code screening criteria. Some issues had already been raised by the Region in the past, so we took special care to provide as much detail as we could. In the absence of an evaluation, the Region also began conducting validation surveys in QAP homes.

Project staff again prepared for a meeting with regional and central office HCFA staff in Baltimore in September 1979. The meeting was arranged to allow an exchange of information between QAP, the Region, and federal representatives of HCFA which included a project presentation on the first year's data from the rural area, "successes" from a case study perspective, plans for physical environment screening, and the need for evaluation. HCFA presented an outline of their timetable for awarding a grant for an independent evaluation and established reporting channels for the State, Baltimore, and the Region.

A site visit in the fall of 1979 from our Project Officer, the Chief of Evaluation Studies, and regional representatives provided a forum to continue discussions and issue resolution on three areas of concern: ironing out details of the approved plan for Life Safety Code screening; continuing to work toward obtaining Medicare approval; and progress toward procuring a federal evaluation.

Medicare approval came in March 1980, and a second site visit from our Project Officer and regional representatives was called shortly thereafter to resolve the paper flow process.

Because an evaluation had not yet been conducted and we were anxious to fully test screening and sampling, we agreed to submit an application to continue the demonstration for a third year. We again completed a Section 1115 waiver application packet and went through the Institutional Review Board's approval for protection of human subjects. We again asked to be considered for funding, but agreed that if funds were not available, we would still like to be considered as a waiver-only project.

Year Three. Approval to continue as a waiver-only project for a third year was granted July 1, 1980 through June 30, 1981. Approval included authorization to continue in our three main test areas (rural, urban and expansion) and the requirement to continue to submit Quarterly Reports to HCFA. An evaluation of the demonstration was simultaneously awarded to Wisconsin Health Care and Research, Inc., WHCRI, (then Wisconsin Health Care Review, Inc.).

Our first priority was to work closely with the independent evaluation team, orienting them to our ongoing and demonstration procedures, scheduling survey observations, participating in initial planning sessions, and setting up channels of communication and access (see Chapter III, Section B, "Liaison with Independent Evaluators").

In January 1981, our Project Officer and the WHCRI federal Evaluation Officer made a two-day site visit. In meetings with evaluation and project staff we discussed six preliminary WHCRI evaluation studies and the possibility of continuing the demonstration for yet another year.

The decision on whether to continue for a fourth year was weighed against the need to modify the survey methods which had been relatively static since the approval to screen for Life Safety Codes was awarded during the second year. We did complete a continuation proposal, with treatment cell changes, some method modifications and, again, a request for funding, although we would agree to approval as a waiver-only project. We went through the completion and approval steps required in the Section 1115 waiver application packet, including approval by the Institutional Review Board. Even in this round, it took several tries for us to correctly list the regulations we needed waived. In April 1981, project representatives traveled to Baltimore to present a progress update to staff of two other long-term care demonstration projects being carried out in Massachusetts and New York and to staff of various HCFA units.

Year Four. Our fourth year proposal contained method modifications detailed in Chapter II. The fourth year continuation request was approved July 1, 1981 through June 30, 1982 as a waiver-only demonstration, with the requirement that we submit a final report to HCFA by August 29, 1982. We also were assigned a new Project Officer, as our original Project Officer had retired from federal service.

A bit of confusion arose in the fall when federal auditors in Baltimore noticed Wisconsin was not doing the 100% inspection of care and was at risk of disallowance of federal financial participation in reimbursement to Medicaid facilities. This apparent failure to comply with regulations was quickly explained once the auditors spoke with our Project Officer.

From the beginning of our fourth year, we were already thinking in terms of winding down project operations and seeking legislative changes or statewide waivers to continue our targeted approach to long-term care regulation. To explore possibilities for continuing some of the screening and sampling concepts after project waiver approval ended in June 1982, we inquired into Section 1115 demonstration options and decided not to submit a continuation proposal. Instead, we submitted a waiver request under Section 1915(b) of the Social Security Act that would enable statewide the option to use screening and sampling in between full reviews which would occur at least once every 24 months. This waiver request was not approved, so planning for wind-down and phase-out continued.

Since the meeting of the three long-term care demonstrations in April 1981, HCFA had been attempting to procure an evaluator to compare these projects. Again, the process of securing a three-state evaluator was delayed, with the result that the Wisconsin demonstration would not overlap with the new contractor's start-up. Therefore, in May, 1982 we requested and were granted a three-month extension of the project's fourth year approval through September 29, 1982. This extension permitted us to: (1) complete the final report; (2) present final findings to New York and Massachusetts demonstration project staff, to HCFA staff and to the new evaluator; (3) effect an orderly transfer of data to the evaluator; and (4) gain the flexibility to demonstrate screening and sampling should the evaluator so request.

As a part of our wrap-up, final reporting required by HCFA was due sixty days after our end date, or by November 29, 1982. HCFA specified that the report must contain a project description, and must, at a minimum, include: (1) identification of the project director, grant number, grantee, and title of the project; (2) a description of initial hypotheses, objectives, study methodology, and findings; (3) a list and copies of publications resulting from the project; (4) acknowledgement of the support received from HCFA and a disclaimer to the effect that the findings do not necessarily reflect policies of HCFA; and (5) an executive summary of the report in camera-ready format.

Pre-Waiver Inspections

Facility Assessments. On November 13, 1978, the project was notified by Region V officials that nine homes were surveyed using QAP methods prior to receiving waiver approval on July 1, 1978. Actually 13 QAP surveys had been conducted prior to receiving formal approval. The regional office informed us that full surveys were to be conducted in accordance with procedures in effect prior

to the granting of the waivers and that failure to do so could result in federal disallowances. In addition, survey packets already submitted to the Region were lacking certain pieces of information necessary for certification even with waiver approval.

Since we had initially been given verbal assurances by HCFA officials that waiver approvals would be effective for the April - June quarter, we proceeded with our April training and May implementation plans without the formal waivers in hand. As a result, we felt that a resurvey of May and June facilities was infeasible for several reasons:

1. The same data were sent to the regional office for certification approval for the QAP homes as was submitted for all Medicaid homes.
2. The homes' compliance with codes and regulations in May or June could not be adequately determined by resurvey in July or August.
3. Costs of resurvey or of marking the forms as Region V was asking would have ranged from 300 to 500 person hours, and the additional workload requirement would have forced suspension of the demonstration for at least a two-month period and would also have thrown off the year's survey schedule.

In January 1979, a meeting was held with our regional representative to determine what documentation was required for the 13 pre-waiver facilities. We agreed to provide Region V with full QAP survey packets for 6 of the 13 homes. After reviewing the survey material, the Region would determine what information was necessary to submit for future screening surveys. We would also provide all missing data for the 13 homes.

The regional office provided us with a list of all information needed and stated that they would determine appropriate action based on review of that data (see Attachment 22). All required information was submitted to the regional office in March 1979 (see Attachment 23).

On October 19, 1979, the regional office notified us of the determination that all 13 pre-waiver facilities met all conditions and standards for participation in the Medicaid Program. The facilities were considered to have been validly certified for the term of the provider agreement (see Attachment 24) with no disruption in federal financial participation.

Resident Assessments. A total of 15 homes were affected by the delay in receiving waivers from the federal government to sample in place of the inspection of care. QAP resident sampling was conducted in eight homes in May and in one home in June of 1978 prior to receiving the waivers. Surveyors returned to each of these homes and completed the full inspection of care. The remaining six QAP homes eligible for sampling were switched to inspection of care. Sampling resumed in mid-July 1978 once the waiver was approved.

Quarterly Showing of Utilization Control Information

Each quarter the Bureau of Quality Compliance submits to Region V a Quarterly Showing which lists all Medicaid facilities reviewed and date of the resident reviews completed during the preceding three-month period. This information is part of the utilization control requirements under the Medicaid Program.

In fall of 1978, QAP staff met with Region V officials in response to one of the conditions imposed upon our approval. We discussed what information would be required on the Quarterly Showing and determined an acceptable reporting format for homes receiving resident sampling. It was decided that all homes receiving resident sampling would be marked with an asterisk on the Quarterly Showing. A separate report, containing data necessary for Region V, would also be prepared for each of the sampled homes. These data were collected by QAP staff from surveyor documents. Project staff then prepared a monthly report which was sent to the Bureau for inclusion in the Quarterly Showing.

We agreed that each home sampled would contain at least one Medicaid recipient in the sample. Inadvertently, in one facility no Medicaid residents were reviewed in the sample although they were present in the home. After discussion with our regional representative, it was determined that it was not necessary to return to that facility to review a Medicaid resident as this omission had occurred early on and procedures were instituted to prevent a recurrence. Toward the end of the demonstration, a sample was completed in a Medicaid certified facility that had no Medicaid residents present on the review dates. In this instance, QAP reverted to bureau policy and contacted the facility each subsequent quarter until a Medicaid resident was present.

In 1981, questions were raised by HCFA officials in Baltimore concerning project data on the Quarterly Showing. After we resolved the initial confusion about why Wisconsin was sampling, project staff were asked to propose a revised procedure which would simplify reporting on the Quarterly Showing. The proposal was sent to Region V officials for their approval. Project staff later met with representatives from Region V and were given verbal approval to implement the revised reporting plan with a few minor changes. The Bureau implemented the revised format in January 1982 (see Attachment 25).

Advisory Panel

With the project's initial approval came nine conditions which had to be met. One condition required "project staff to include a gerontologist, having considerable experience in long-term care." We considered how this requirement could best be integrated with the project's needs for access to a diverse range of "gerontological experts."

At a meeting with HCFA regional and central office staff in August 1978, this condition was discussed. Wisconsin decided to assemble a panel of persons with expertise in the area of long-term care. This inter-disciplinary group was to be comprised of six to ten experts from the Wisconsin long-term care industry, academia, and state personnel. A core group was designated and it included a geriatric nurse practitioner, physician, social worker, speech pathologist/audiologist and physical therapist. Others, such as nursing home administrator, occupational therapist, engineer/architect, etc., were consulted as needed. Initially, core panel members were available to the project two days a month.

Individuals on the panel assisted us in meeting other approval conditions. They also reviewed the quality criteria to be used in screening and sampling and recommended changes. In addition, data collected during the "pre-test" were reviewed by the panelists who assisted in developing scoring protocols and in interpreting results.

Year One. The first panel meetings were held in two parts due to the size of the group. The Nursing Home Administrator Panel met November 16, 1978. The purpose of the meeting was to critique the role of the advisory nursing home administrator and the forms used for new method surveys. Recommended changes developed by this group were considered along with input from surveyors and from the core Advisory Panel.

On December 4, 1978 the core Advisory Panel again met to critique the facility and resident assessment worksheets. This critique included reviewing the worksheets for quality of medical care considerations as HCFA had requested. The goals for the panel were to revise forms, clarify the role of the advisory nursing home administrator, and suggest ways to improve surveyor training. In January 1979, a second panel meeting was held to complete the forms revision process from a physical environment and dietary perspective.

In February, we held the first joint panel meeting, merging the nursing home administrators with the other health care professionals. At this meeting, bureau staff updated the group on changes in the ongoing regulatory process and related these changes to the demonstration methods.

In April 1979, the panel met again to review the proposed role of the engineer and the plan to expand into the Madison and Green Bay districts. First-year data and implementation problems were brought up for discussion.

Year Two. We learned that, effective July 1, 1979, the need for gerontologic expertise was no longer a condition of project approval. We felt, however, that the Advisory Panel was helpful, and panel members agreed to continue their role, although the panel would meet less frequently.

In October 1979, the panel met to review data collected in pre-test homes. As experts, they were asked to rate the homes on overall quality of care so that their ratings could be used to validate the quality scores calculated through a weighted point system used by non-professionals. Also discussed were:

- Problem with maintaining adequate numbers of volunteer administrators.
- Surveyor reluctance to give up the code checklist.
- Timetable for obtaining an independent evaluation and approval to screen Medicare homes.
- Need for revised procedure manual.

Years Three and Four. No meetings of the Advisory Panel were held in 1980, although we regularly mailed copies of our Quarterly Reports to panel members.

In February 1981, the panel convened for the last time. At this session, statewide adoption of certain QAP components was announced. The independent evaluator presented results of their studies to date. The "fourth year of the demonstration" was also discussed, including the changed fourth year scenario and planned developmental work on assessing quality of resident care.

In May and June of 1982, project staff met individually with advisory panelists to update them on the status of the demonstration and to obtain their suggestions for training nurses and social workers in quality of care assessment. They were also asked to critique the preliminary draft of our Executive Summary.

Summary. Six of our advisory panelists were with us from the outset. Twelve others were active for only parts of the four years due to changing needs in expertise and to individuals withdrawing as a result of other commitments. The Advisory Panel met seven times at varying intervals, and was consulted one-on-one more frequently as needed throughout the course of the demonstration. Although at the outset the group saw themselves in a "watchdog" role, they in fact assisted in clarification of the roles of the nursing home administrator and physician, forms revision, and pre-test scoring. The six panelists who stayed with the project for the entire four years were especially helpful resources as they maintained a level of informed involvement throughout that was an important point of reference as the methods developed. (See Attachment 26 for a chronology of panel members and meetings.)

Life Safety Code Approval

In 1978, waivers were requested to screen for the Life Safety Codes and later modified to include the entire physical environment condition. The primary objective of the screening process was to reallocate engineer time in the most cost-effective manner. Similar

to the health surveyors, the architect-engineer spent no more time in facilities with problems than in those having a good record of code compliance. In addition, little time was available for consultation with providers to review building plans or completing construction inspections. The secondary objective was to spend more time in facilities with long-standing problems and allocate more time for plan review and construction inspection, hopefully saving dollars in post-construction efforts to meet code requirements.

In our initial request, we proposed that engineers would begin by reviewing the previous surveys for all facilities eligible for a screening survey. He or she would determine if the home had a history of being largely in compliance with the Life Safety Codes. Based on this assessment, the home would be scheduled for either a full survey by the engineer or a screening survey of the engineer area by the other health surveyors. If the engineer determined that the screening survey would be appropriate, the health surveyors would review the home in the areas of Facility Appearance/Environment and Facility Safety (see Attachment 27).

New survey method teams would also receive training in checking the critical factors affecting life safety conditions which can change in a nursing home from year to year. With this training in mind, code violations or questionable safety practices noted at the time of survey would be relayed to the engineer who would make an on-site inspection of the facility within ten working days and cite deficiencies if warranted.

The waivers requesting permission for the engineer to participate in facility screening were not granted in 1978.

During the first year of project implementation, project staff and bureau architect/engineer personnel developed and refined the screening process for the Life Safety Codes and again requested a waiver for the entire physical environment condition. Unlike our previous request, the engineer would be participating on all screening surveys. The health surveyors would not assume a portion of the engineer review.

Criteria were developed to determine which facilities would be eligible for engineer screening. The only facilities eligible for screening would be those with a history of: a) being largely in compliance with the Life Safety Codes; b) being prompt in correcting deficiencies; and, c) having no change in administrator.

In addition, a survey technique for the engineer was developed which consisted of three parts. The survey would begin with a general tour of the facility to gain an overall impression of facility operations and detect problem trends. The main emphasis of the survey itself was then placed on maintenance of fire safety systems and on emergency preparedness. Once the survey was completed, the engineer could choose to complete a full survey based on his or her findings or return during the year to complete an interim survey.

Our 1979 waiver request was approved pending resolution of the following issues (see Attachment 28):

1. A screening tool similar to that utilized for the health portions of the survey should be developed.
2. Terms such as "largely in compliance" and "regression of prior compliance" should be elaborated on and defined.
3. Facility selection criteria need to be fully described and defined.
4. Basic ground rules should be developed for all surveyors; clarify steps in selecting a facility and determining at what point a full survey is required in order to provide some control and consistency for the process.

Once approval to screen for Life Safety Codes was secured, project staff quickly met with bureau staff to resolve the above-mentioned issues to the satisfaction of the regional office and to prepare for training and implementation in September.

Drawing upon engineer expertise within the Bureau, QAP staff began to further develop and refine the engineer role in the project. The first priority was to define criteria for engineer eligibility for screening and develop standards to use in deciding which homes should receive the screening survey in place of the full Life Safety Code review. Our next task was to develop and print the engineer screening tool and to revise the current Screening Survey Manual to include engineer participation (see Attachment 29).

In November 1979, Region V officials met with bureau staff to discuss common concerns. At that time, regional officials were able to review the project's revised engineer role. Region V staff approved the engineering role with minor revisions (see Attachment 30). The engineer would be required to complete the full federal Life Safety Code portion of the survey instrument when:

1. s/he has not surveyed the facility previously; or,
2. there have been additions to the building, or changes in usage of areas which invalidate the past integrity of the Life Safety Codes;
3. deficiencies are discovered which may affect the decision to continue approval of past waivers; or,
4. a new waiver is requested; or,
5. a waiver has been previously denied.

Consumer Group Involvement

The concept of consumer involvement in QAP surveys was never well defined nor fully implemented. At start-up, a Nursing Home Ombudsman Program was attached to the Office of the Lieutenant Governor. During year one, we established a formal channel for the Ombudsman to use in conveying to us their overall assessment of quality of a home's care delivery based on their contacts with consumers. This information was used by surveyors along with bureau records in deciding whether to screen and sample or do a full survey and inspection of care.

A great deal of interest in the project had been aroused among consumer groups. To explore whether further consumer involvement was feasible, we began looking at who could be considered a consumer, projected costs attendant with each scenario for consumer useage, and what that consumer's role might be in the survey process.

In October 1978, project staff distributed a questionnaire to bureau staff and nursing home association representatives to canvass respondents on what role, if any, a consumer might play in the long-term care quality assurance process. The concensus was that consumers should definitely have a role and suggestions ranged from "monitoring the patient care program" to "lobbying the Legislature and Congress."

In May 1979, we completed a more focussed assessment on the feasibility of consumer involvement. A consumer participation survey was sent to consumer and other interest groups involved in issues on aging. Responses were few and suggested only limited enthusiam for participation in QAP surveys given their other commitments and missions.

In our second year continuation proposal, we indicated that "Consumer input, an important resource in the long-term care quality assurance process, will continue to be solicited. A formal role may be possible for the consumer in the new state survey process. If consumer participation is recommended, separate grant monies will be sought to implement the concept." However, we did not pursue the consumer role given the lack of response from consumer groups and the additional administrative responsibilities a separate grant proposal would have entailed.

Medicare Approval

In January 1978, when we first discussed the demonstration project concept with Region V staff, we were forewarned of problems in obtaining approval to test QAP methods in facilities certified as providers in the Medicare Program. We received a letter from Region V explaining that Medicare responsibilities were contained in a state-region "1864 Agreement" which could not be "waived". (1864 is the section of the Social Security Act which pertains to this agreement.) Further, the Region was also unsure that they had the authority to amend the 1864 Agreement to enable screening in Medicare facilities.

In July 1978, we knew officially that approval to screen in Medicare homes could not be obtained through Section 1115 waiver authority. Our inability to utilize screening in Medicare homes created an immediate problem in our original experimental design, since all Medicare certified facilities had to be switched to an "old" survey cell. There was also a problem when facilities elected Medicare certification mid-way through the demonstration. Due to an error in communication with our regional office, a screening survey was completed in a home that had previously requested Medicare certification. It was necessary for the home to be resurveyed for Medicare requirements.

We were still convinced that to fully test the methods we needed to demonstrate screening in Medicare as well as Medicaid homes. (Note that we had no barriers to sampling in Medicare facilities since resident review applied only to Medicaid recipients.) In our proposal to continue for a second year, we again requested Medicare approval. We were somewhat more optimistic since the regulations had been redrafted subsequent to our initial disapproval. It seemed that requirements of the Medicare and Medicaid Programs had been combined to enable congruent approval of waivers and changes in the Medicare statutes had been proposed. We were again told that the Secretary of the Department of Health and Human Services did not have authority to waive the necessary Medicare regulations.

It appeared that our inability to screen in Medicare homes would result in increasing problems for the demonstration in the fall of 1979. As a part of the Medicaid Administrative Code about to be promulgated in Wisconsin, a requirement for nursing home participation in Medicaid specified that six Medicare SNF beds per thousand elderly be made available throughout the State. As a great number of homes would be applying for Medicare certification, we again sought approval to screen in Medicare homes. Approval was especially critical since we planned to add the expansion district homes to the demonstration which would dramatically increase the number of facilities affected.

Our Project Officer and regional representatives supported our request and assisted in expediting an approval decision. In March 1980, we received permission from HCFA to use QAP screening methods in Medicare homes. Discussions with our Project Officer and regional representatives in April led to procedures for implementing Medicare approval.

The following procedure for recertification for QAP Medicare/Medicaid homes was effective June 30, 1980:

Bureau staff will submit to the Region the following documentation:

1. Certification and Transmittal (HCFA 1539).
Before signing off on the above form, bureau staff will review all QAP survey documentation to determine if the facility is in compliance with the conditions of participation.

2. Request to establish eligibility (HCFA 1516)
3. QAP Screening Assessment Face Sheet (yellow Copy)
4. QAP Summary of Findings forms (RN, RS, SW, PE - Yellow Copies)
5. Notices of Violations
6. Crucial Data Sheets for SNF, ICF, Fire Safety Surveys
7. Staffing Pattern

NOTE: If a waiver was requested, appropriate waiver documentation had to be submitted also.

When the Region reviewed the documentation for Medicare facilities and wanted additional survey documentation, they would send a copy of the facility certification letter, indicating a cancellation date, to the Chief of the Bureau's Facility Regulation Section. The Section Chief would notify QAP staff, who would forward survey follow-up reports to the Region.

The bureau procedure for submitting required documentation for recertification of Medicare and Medicaid facilities (non-QAP) is listed in Attachment 31.

Federal Validation Surveys

From September 1979 to April 1980, Region V surveyors completed five federal validation surveys in homes that were eligible to receive the screening survey. Four homes had actually been screened prior to the federal survey. Each survey report from Region V was reviewed by project staff, discipline supervisors, and, if warranted, surveyors assigned to the facility.

A response was prepared by comparing each code found out of compliance by the federal survey team to the most recent state survey (see Attachment 32 for a sample response). This comparison proved to be difficult since the focus of the two surveys was quite different. In QAP, surveyors were asked to screen the facility to determine if resident care needs were being met. Surveyors assessed the care delivery systems within the nursing home by observing resident care outcomes and they were given the option to choose an alternate method of requiring correction if they found the facility out of compliance with a state or federal code which had no direct impact on quality of care. In contrast, federal surveyors checked each code and cited all observed deficiencies. However, state surveyors conducted follow-up on all resident care related problems found by federal surveyors where needed.

In September 1980, the independent evaluator, WHCRI, asked Region V to complete 20 federal validation surveys for use in a data study to compare the effectiveness of QAP and non-QAP methods. These validation surveys are more fully described in Chapter III, Section B, "Liaison with the Independent Evaluators".

B. PROJECT ADMINISTRATION

QAP Organization and Responsibilities

Administrative staff of the Quality Assurance Project were divided into two units - Field Operations and Data Monitoring. Each unit had separate but overlapping responsibilities. The head of each unit reported to the project director. In addition, we had various contractual arrangements over time with the University of Wisconsin which permitted the project to obtain additional specialized staff and services as needed.

Field Operations Unit. The Field Operations Unit of the Quality Assurance Project was developed during March of 1978. Originally made up of 4.5 full-time equivalents (FTE), the size of the unit has fluctuated between 3 and 5.5 FTEs. Staff within the unit reported directly to a unit head.

At the onset of the demonstration, the major responsibilities of this unit were:

- information dissemination
- scheduling
- training
- interface with ongoing bureau operations, such as paperflow
- surveyor response
- documentation monitoring/field observation

The Field Operations Unit was responsible for formulating all start-up procedures and also for assuring smooth functioning of daily project operations "in the field". These tasks included development of a procedure manual, continued training for surveyors and nursing home administrators, establishing routine scheduling procedures, and coordination with ongoing bureau activity.

Over the four years of the demonstration, the activities of the Field Operations Unit have remained basically the same. Besides survey monitoring, scheduling, and other routine tasks, we have revised and expanded procedures and addressed training needs as they have arisen.

As the demonstration area expanded, individual field operations staff were assigned to specific districts for purposes of acting as a liaison between surveyors, the project, and central office. Staff assigned to the district observed surveys and attended district scheduling meetings but did not have line authority over the field staff. QAP field monitors worked closely with the eight field supervisors throughout the demonstration.

Data Monitoring Unit. The Data Monitoring Unit of the Quality Assurance Project was responsible for all data monitoring of project functions. It contained three full-time equivalent staff members - the head of the Monitoring Unit, one full time data clerk, and two half-time clerical assistants. The unit head reported directly to the project director.

The unit's primary responsibility was to to design, conduct and analyze data studies which assessed implementation of QAP methods. Upon initial project start-up, a number of routine monitoring studies were established and these studies were carried on for the duration of the project. (Attachment 33 contains an annotated listing of all routine QAP monitoring data.) In addition, special studies were designed and conducted to answer specific questions or to test QAP hypotheses. (Attachment 34 contains a complete listing of these special studies.)

Interchange between the Monitoring Unit and the Field Operations Unit was crucial to effective data collection. Often studies were initiated in response to concerns and questions identified by Field Operations staff. Results of all studies were fed back to the Operations Unit to help identify training needs and priorities.

In addition to data studies, a number of other data tasks fell under the jurisdiction of the Monitoring Unit. (1) Staff conducted file checks on advisory nursing home administrators. We periodically reviewed the survey files of nursing home administrators who acted as project advisors to ensure that they were administrators in good standing. New candidates for advisory administrators were also reviewed. (2) On a monthly basis, we calculated level of care histories and random number listings for homes scheduled for an annual visit in preparation for QAP resident sampling. (3) We maintained a manual tickler system for tracking completion of surveyor follow-up actions to the survey process. (5) We researched the survey and complaint status of homes which were under consideration by the Bureau's Problem Facilities Meeting. (6) The unit was also responsible for preparation of the project's annual budget.

The Monitoring Unit also acted as liaison with the project's outside statistical consultants. These consultants were staff at the University of Wisconsin Statistical Laboratory. Monitoring unit staff were responsible for arranging joint meetings as needed, facilitating communication between project staff and the consultant, and for processing billable accounts for services provided.

Finally, the Monitoring Unit was the first point of contact for the independent evaluator and others wishing access to project data. Monitoring unit staff worked with the Department's Bureau of Evaluation and Office of Information Systems to carry out studies.

Staff Numbers and Chronology. Project administration has evolved in response to changing needs and funding approvals. Table 21 displays staff hired prior to initial approval. At this time, successfully completing the demonstration approval process and planning for implementation were the first priorities. Staff drafted two grant requests (one contingent upon funding, the other not), developed evaluation plans, wrote procedures for field staff, held training sessions and set up filing, supplies and paper flow procedures.

In year one (see Table 22), there was a dual emphasis on monitoring and field operations activities. Staff began routine data collection for internal monitoring and program evaluation purposes and standardized procedures and surveyor performance through further training of field staff.

Year two (Table 23) saw continued effort to maintain field staff performance as we expanded operations to include over half of the State's homes. Data collection activities were routinized.

In year three (Table 24), the monitoring and field operations units worked closely together to combine data analysis and subjective assessments in a critique of the effectiveness of the demonstration methods and suggested areas needing improvement.

Year four (Table 25) marked the start of wind-down activities. Staff levels reflected continuing budget constraints. Emphasis on field activities took a back seat to data studies and final reporting considerations. There were little or no consultation or public information activities.

In phase-out (Table 26), a "skeleton" crew, with tenure on the project averaging 2.6 years, performed wind-down and phase-out activities almost as complex and exacting as at start-up.

Outside Consultation. From the outset, it was evident that the Bureau of Quality Compliance lacked the technical expertise to resolve methodological, evaluation and statistical questions attendant to the demonstration project. A series of interchange agreements were set up with the University of Wisconsin to ensure access to the staff of the Center of Health Systems Research and Analysis, the Statistical Laboratory, and the Schools of Law and Nursing.

As support for our experimental design and data analyses, we obtained input on whether the control and treatment groups insured an adequate sample size for data analysis, on our resident assessment sampling plan, on approaches to evaluation, and on analyses of all hypotheses. We also obtained assistance in setting up specific studies, such as on the impact of sampling on facility reimbursement and a comparison of costs under the demonstration versus the ongoing process.

Table 21

Pre-Approval Staff

	1977 NOV.	DEC.	1978 JAN.	FEB.	MAR.	APR.	MAY	JUNE
Co-Director (Fryback)	-----							
Co-Director (Smelser)	-----							
Stat Clerk (Arneson)	-----							
.5 Research Asst. (Hagen)							-----	
Chief Field Ops. (Richardson)	-----							
Procedures (Dobbe)					-----			
Paperflow (Benesh)					-----			
Information (Fallon)							-----	
Typist (Loutenhizer) (Syens)	-----							

AVERAGE FULL TIME EQUIVALENTS = 6.1

Table 22

Year One Staff

	1978					1979						
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
Co-Director/ Director												
(Fryback)			/									
Co-Director/ Specialist												
(Smelser)			/									
Planning Analyst (Morris-Jones)												
(Arneson)									/	/		
Stat Clerk (Arneson) (Swenson)									/	/		
.5 Research Asst. (Hagen) (Weitzman)												/
.5 Data Clerk (Streeter)									/			
Chief of Field Ops (Richardson)												/
Procedures (Dobbe)												
Field Monitor (Joiner)						/						
Paperflow/Review (Benesh)												
Information (Fallon) (Gibbons)				/			/					
Typist (Syens) (Sage)				/	/							

AVERAGE FULL TIME EQUIVALENTS = 9.5

Table 23

Year Two Staff

	1979				1980							
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
Director												
(Fryback)												
Specialist												
(Smelser)				/								
Planning Analyst												
(Arneson)(Stewart)					/	/						
Stat Clerk												
(Swenson)(Crooks)				/	/							/
.5 Research Asst.												
(Weltzman)(Jerusis)						/	/					
.5 Data Clerk												
(Ringel)	/					/						/
Chief of Field Ops												
(Beam)(Joiner*)				/		/	/					
Procedures/												
Field Monitor												
(Dobbe)(Neaves)		/	/									/
Field Monitor												
(Joiner)(Benesh)						/		/				
Paperflow/Review												
(Benesh)(Sage)								/		/		/
Information												
(Gibbons)												
Typist (Sage)												
(Outerbridge)												
(Starling)							/	/	/	/	/	/

*Also served as Project Administrator

AVERAGE FULL TIME EQUIVALENTS = 9.3

Table 24

Year Three Staff

	1980					1981						
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
Director (Fryback)												
Planning Analyst (Stewart)												
Stat Clerk (Anderson)			/									
.5 Research Ass't. (Jerusis)												/
.5 Data Clerk (Ringel)												/
Chief of Field Ops (Joiner*)(Dobbe)						/		/				
Field Monitor (Neaves)			/									
Field Monitor (Benesh)												
Paperflow/Review (Crooks)			/									
Information (Westbrook)			/									/
Typist (Starling) (Markgraf)				/		/						

*Also served as Project Administrator

AVERAGE FULL-TIME EQUIVALENTS = 6.7

Table 25

Year Four Staff

	1981				1982							
	JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUNE
Director												
(Fryback)												
Planning Analyst												
(Stewart)												
Stat Clerk												
(Anderson)												
. 5 Research Anal.												
(Ringel)	/											
Data Clerk												
(Jansen)(Mahlk)					/			/				/
Chief of Field Ops												
(Dobbe)												
Field Monitor												
(Benesh)												
Paper Review												
(Crooks)												
.75 Typist												
(Markgraf/												
Anti(junti)												
. 5 Records Librar.												
(Stults)							/					

AVERAGE FULL-TIME EQUIVALENTS = 7.5

Table 26

Phase Out Staff

	1982		
	JUL	AUG	SEPT
Director (Fryback)	-----/		
Planning Analyst (Stewart)	-----/		
.5 Research Anal. (Ringel)	-----/		
Chief of Field Ops (Dobbe)	-----/		
Field Monitor (Benesh)	-----/		
Paper Review (Crooks)	-----/		
.5 Typist (Markgraf)	-----/		
.5 Records Librar. (Stults)	-----/		

AVERAGE FULL TIME EQUIVALENTS = 5.3

Through the interchange agreements with the University of Wisconsin, we received consultation in several developmental areas. One example was an analysis of which legal issues would have to be resolved at the state and federal levels if screening and sampling were to be implemented on an ongoing basis. We also had access to professional expertise in further defining key quality of care indicators through the School of Nursing. A University consultant from the School of Nursing facilitated sessions where bureau staff developed quality criteria which were then validated with national experts.

At start-up we believed we would be responsible for the project's evaluation. We therefore contracted with Opinion Research Associates to administer a pre-test questionnaire to rural and urban nursing homes. QAP and university staff conducted an initial analysis of the data. The tool and findings were later forwarded to the independent evaluator, WHCRI, for their information and use.

Table 27 summarizes consultation services provided to QAP for the duration of the project.

Field Staff

Nursing home surveyors are located within two sections in the organization of the Bureau of Quality Compliance. Nurse, sanitarian and social worker surveyors are in the Long-Term Care Section, and engineer/architect surveyors are in the Facilities Needs Analysis Section.

The surveyor line supervisor structure within the Long-Term Care Section has undergone several changes during the project's operation. When QAP began in the spring of 1978, each surveyor discipline had a same-discipline line supervisor. For all nurse surveyors, a supervisor was located in four of the eight district offices around the State: a nurse supervisor in Eau Claire supervised nurses in the Eau Claire, La Crosse and Wisconsin Rapids districts; another in Green Bay supervised nurses in the Green Bay, Rhinelander and Fond du Lac districts; and one nurse supervisor in Madison and one in Milwaukee supervised nurses in those district offices. One sanitarian and one social work supervisor were located in the central office, and each supervised all surveyors in their respective disciplines. Surveyor line supervisors were in turn under the Long-Term Care Section Chief.

Engineer/architect surveyors, within the Facilities Need Analysis Section, were supervised by one centrally-located section chief.

In March 1980 several central office and field staff positions were "frozen" due to budget constraints. This made it necessary for the Chief of the Long-Term Care Section to take over supervision of the social workers. Consequently the Section Chief had considerably less time available for social work surveyors.

Table 27

Consultation

	Pre-Approval	July 1978	Year One	July 1979	Year Two	July 1980	Year Three	July 1981	Year Four	July 1982	Phase Out
UW Center for Health Systems Research & Analysis											
.20/.05 Gustafson	/	-----	/	-----	/	-----	/	-----	/	-----	/
.5 Research Assistant											
(Crosby) (McEniry) (Marty)											
Staff of UW Stat Lab (as needed)	/	-----	/	-----	/	-----	/	-----	/	-----	/
UW Law School											
.05 Handler											
.5 Research Asst. (Goodman)											
UW School of Nursing											
Calkin (as needed)											
Opinion Research Associates											
(fixed contract)	/	-----	/	-----	/	-----	/	-----	/	-----	/

In August 1981, the Madison nurse supervisor retired. Anticipating reorganization of the surveyor supervisory structure, the Bureau temporarily assigned the sanitarian supervisor as supervisor of nurse, social worker and sanitarian surveyors in the Madison district office.

Therefore, at project's end there were a total of three nurse supervisors responsible for all but the Madison district nurses. The sanitarian supervisor supervised all sanitarians as well as the Madison nurses and social workers. Remaining social workers were supervised by the Long-Term Care Section Chief; however expertise in social service matters was provided by the former social worker surveyor supervisor. The structure of the engineer/architect section remained unchanged.

Liaison with the Bureau of Quality Compliance

From the onset of the Quality Assurance Project until phase-out, project staff consistently kept personnel in the Bureau of Quality Compliance informed about QAP operations. In most cases bureau staff have been involved in project development, problem solving and special events such as training. In addition, project staff attended regular bureau meetings and were involved in many bureau projects where QAP ideas or expertise could be contributed.

Bureau staff, particularly those in the Long-Term Care Section, were involved in development of the new survey method ideas, procedures and forms. When the initial training session was held for start-up in the rural districts, bureau attendees included all Bureau consultants who worked within the demonstration area, surveyor supervisors, the Bureau Director and Deputy Director, Chief of the Enforcement Section, and Chief of the Facilities Regulation Section. After training, liaison efforts concentrated on meeting with bureau personnel responsible for facility survey and certification. This effort ensured that the certification process for demonstration district homes would be smoothly completed and problems could be anticipated and avoided.

Beginning in the last quarter of 1978, QAP began monitoring demonstration facilities identified as "marginal" and presenting information on their status to a bureau committee which tracks the progress of marginal facilities. This process continued throughout the duration of the project.

As a way to further enhance bureau involvement in the project, discipline supervisors were encouraged to increase their role in field monitoring and staff training. Additionally, in the spring of 1979, supervisors agreed to hold regularly scheduled meetings with QAP staff to increase and improve communications.

Also in the spring of 1979, a plan to have documentation review staff in the Bureau monitor QAP reports was developed and later implemented in September. The decision was made to transfer some of QAP documentation review responsibilities to the Bureau because with project expansion, the number of facility surveys to be reviewed had increased substantially. Documentation review staff and their supervisor observed a QAP survey and were trained to review QAP survey packets.

During the second year of the demonstration QAP staff began attending ongoing bureau meetings. We also continued to hold regular sessions with surveyor supervisors on such topics as expansion and field problems.

As budget and staff cuts put surveyor time at a premium, QAP moved to incorporate surveyor training into regularly held bureau in-services. This change occurred during the third year of the demonstration. Although it shortened the time available for QAP in-service, it was a necessary change. In the same year the Bureau created an Employee Advisory Committee, and a QAP staff member became a representative on the committee.

Later in the third year of the demonstration, several major issues arose which required substantial interface between QAP and bureau staff. These issues included the following:

1. We attempted to balance district staff QAP and non-QAP workload in response to social worker and nurse vacancies.
2. We negotiated a means for the project to conform to a new state administrative order requiring identification and referral of nursing home residents who require additional services and/or alternate placements.
3. The use of physicians in reviewing Medicaid ICF residents was explored and a policy established.
4. The State's role in reviewing private pay residents (complicated by statutory restrictions on access to medical records) was raised by QAP staff. We felt that handling of private pay patients in the QAP resident sample depended on resolution of this wider issue.
5. QAP and the Bureau resolved a means for handling out-of-state residents in demonstration homes. Since 1976, under a special agreement with the State of Illinois, BQC has performed evaluations of Illinois residents in Wisconsin nursing homes. It was decided that all of these residents would be reviewed apart from and in addition to residents in the QAP sample (see Attachment 35).
6. Due to the fact that an increased number of bureau central office staff had been observing QAP methods in demonstration homes, QAP revised its procedures for scheduling observers.

7. A new bureau consultation form was instituted and QAP surveyors were instructed to use it in lieu of a QAP form.

When the rural districts returned to full surveys and inspection of care in April 1981, QAP worked with the Bureau in piloting some QAP survey components for possible use on a statewide basis. This effort marked the first time that QAP components had been considered for adoption. Two innovations were field tested: 1) tighter scheduling of team surveys monitored by supervisors; and 2) strategy sessions conducted by surveyors at scheduling meetings. These piloted components were later implemented statewide. QAP was closely involved throughout piloting and implementation.

Another effort on which QAP and the Bureau worked closely was reassessment and refinement of the Bureau's inspection of care process. This joint effort started in the spring of 1981, and training in the resulting quality of care indicators was still in progress at the end of the QAP demonstration. The Bureau and QAP worked together in identifying key indicators of good quality of care for use during the inspection of care process. A University of Wisconsin consultant played a key role in this development by leading a panel of surveyors, supervisors and industry representatives.

As the project phased out of operation, QAP staff presented project findings and recommendations to the Bureau. A formal presentation was made at a bureau retreat in January 1982, where QAP staff presented an analysis of QAP successes and failures. This presentation, and a similar position paper, were intended for bureau use in deciding what QAP components to adopt or discontinue.

In addition to the above-mentioned bureau liaison activities, QAP has worked with BQC on the following special projects:

1. development of a computerized event tracking system (later modified),
2. forms committee for forms critique and development,
3. variable survey cycle development committee,
4. design of a surveyor activity hour reporting system, and
5. revision of reporting format for QAP resident assessment statistics.

Additionally, ongoing liaison activities included update and training sessions conducted by QAP for bureau clerical staff and documentation reviewers, and orientation for employees new to the Bureau.

Liaison with Independent Evaluators

From the beginning of project planning and development, staff were aware that an evaluation of the project would ultimately be needed to determine its success. However, at that time it was unclear who would be responsible for conducting the evaluation. Therefore, project originators developed and tested an evaluation tool which was included as part of the original project proposal.

This tool, referred to as the "pre-test", was developed and tested prior to project start-up. Initial developmental work was conducted by a University of Wisconsin consultant in January and February 1978. The draft instrument was then piloted in March by project staff.

The pre-test met two important and related needs. First, it was a step towards development of an evaluation tool which could ultimately be used to verify effectiveness of project methods, either by project staff or by an outside evaluator, should one be appointed. Second, it provided a means to obtain pre- and post- quality scores for facilities in the demonstration area. Since project methods were getting underway, it was important that a baseline measure be obtained. A post-measure could later be administered and results compared to determine whether project methods had resulted in improved quality of care.

The design of the pre-test proceeded as follows: A group of experts familiar with long-term care identified factors that they considered to be important in judging quality of care in nursing homes. Such factors included resident condition, resident-staff relationships, dietary aspects, facility appearance and environment, recreational activities, resident-community activities, facility safety, care management, staff/professional ties, and management and philosophy. Using these factors, another panel of experts designed the following questionnaires for the pre-test:

- 1) a self-report questionnaire which asked basic questions about the administration and staffing of the nursing home;
- 2) a facility observations questionnaire;
- 3) a person in charge questionnaire;
- 4) a director of nursing questionnaire;
- 5) a nurse's aide questionnaire;
- 6) a nurse's aide/resident observation questionnaire;
- 7) an activities coordinator questionnaire;
- 8) a food service supervisory/dietary observations questionnaire;

Apart from these questionnaires, the panel designed a scoring mechanism whereby the information on the pre-test could be quantified and thus each home could receive a total score representing the degree of quality of care. The scoring mechanism was based on a previous ranking and rating of the quality factors by the first group of experts. From this assessment, weights were assigned to each question of the pre-test. Total possible scores varied between 441 and 451 depending on the type of patients per home (i.e., SNF, ICF), but all scores received a normalized score based on a scale from 0-100.

The project contracted with Opinion Research Associates to administer the pre-test upon its completion. A group of trained interviewers administered the pre-test to 128 rural district homes in April, May and June 1978. They also administered the pre-test to 40 homes in the urban district in early 1979.

Using data gathered in the rural districts, project staff assessed the reliability and validity of the pre-test. It was concluded that the pre-test did address issues related to quality of care in nursing homes and could distinguish degrees of quality of care. However, it was also apparent that the scoring mechanism needed to be refined, weighting of questions needed to be reassessed, and the questionnaires themselves needed modification. Results of this assessment are reported in Attachment 21 of the Quality Assurance Project Quarterly Report, July-September, 1979.

Although project staff did not undertake any further development of the pre-test, it did become the basis for the quality assessment questionnaire used by our independent evaluators to measure the effectiveness of QAP methods.

In 1980, the Health Care Financing Administration funded a two-year evaluation of the project by Wisconsin Health Care and Research, Inc. (WHCRI). The duration of the evaluation overlapped the last two years of the project, 1980-81 and 1981-82, and thus it was necessary to establish an interface between the two projects which would both facilitate the evaluator's access to the project and keep project staff abreast of evaluation activities. This interface was established at the outset and was maintained for the duration of the evaluation. It proved to be a functional and beneficial means of maintaining communication between the two projects.

Upon start-up of the evaluation, QAP arranged an initial introduction of WHCRI staff to bureau staff and functions. As a part of this introduction, lines of access to bureau files and staff were formalized. QAP also assisted WHCRI with resolving legal questions regarding access to confidential resident files.

Once the evaluation was underway, QAP staff followed the progress of evaluator activities and assisted when requested by WHCRI. All WHCRI requests for staff time and for bureau or project data were channeled through a contact person within the project. Project staff then explored the feasibility of the request and wherever possible made all necessary arrangements for the requested assistance.

Project staff also had an opportunity to read and critique preliminary drafts of WHCRI evaluation reports. We reviewed their preliminary data studies and provided both verbal and written feedback. Where appropriate, we also gave feedback on interpretation of findings and suggested alternate interpretations of observed trends.

QAP staff prepared internal reports on the status of the evaluation. A monthly status report was prepared for the bureau director to keep her up-to-date on evaluation activities. A quarterly status report was prepared for the head of the Wisconsin Department of Health and Social Services. QAP staff also assisted with arrangements for WHCRI staff to make periodic presentations to administrators in both the Bureau and the Division of Health.

In most instances, QAP and the Bureau were able to provide requested assistance to WHCRI. Appropriate bureau and QAP staff trained WHCRI surveyors in QAP screening and sampling methods and in the mandated full survey and inspection of care methods. This training included nursing, sanitarian and social work codes and regulations. The Bureau provided surveyors and supervisors for the panels of raters used in the problem severity and recidivism studies. When requested, QAP staff helped WHCRI locate needed bureau files, particularly notices of violations. In some instances, especially in the early stages of the evaluation, QAP staff shared with WHCRI the raw data which we had collected. QAP also assisted with the second study of surveyor time allocation and was responsible for data collection.

There were two primary evaluation studies on which we were unable to provide the requested assistance. On the study of reliability of level of care assessments, WHCRI requested that state surveyors be made available to assess resident care levels in selected homes. Due to staff workload, the Bureau was unable to provide any of the requested time. Second, on the litigation study which compared enforcement actions under the new and old methods, WHCRI requested that appropriate bureau and legal staff review WHCRI's outcome assessments and provide a second opinion on these judgments. Again due to workload, we were unable to review enforcement actions contained in the study.

One evaluation study in particular involved an extensive interface between WHCRI, project, and bureau staff. In September 1980, WHCRI commissioned Region V to complete 20 federal validation surveys for use in an evaluation data study. Ten of the homes had received the new method survey, and 10 homes had received the old method. When WHCRI encountered problems in making comparisons between state and federal survey reports, they requested assistance from bureau and project staff.

QAP assumed responsibility for reviewing and responding to the 10 new method homes. Bureau staff reviewed and responded to the 10 old method homes. A response was prepared by comparing each code found out of compliance by the federal survey team to violations issued by state surveyors on the most recent state survey. Letters of response were sent to Region V and to our Project Officer. Results of the comparisons were shared with WHCRI.

Liaison with Outside Agencies

Since QAP was a "national" demonstration, the task of fully informing all interested groups about project objectives, methods and status was a priority. This information dissemination was accomplished through a variety of contacts and diverse publications.

As a condition of initial approval, we were required to submit quarterly reports to HCFA covering progress, significant observations, and current and cumulative data. Problems and resolutions were also to be incorporated. This condition remained in effect throughout the demonstration.

We supplemented the federal requirement for quarterly reporting with three annual reports, one technical report and a final report including an executive summary. These publications have been distributed to bureau and project staff; state, regional and other federal health care regulators; professionals and organizations in health-related fields; and to Wisconsin consumer groups and nursing home associations. In addition, selected state legislators, nursing home administrators who are in our advisory "pool", and administrators of facilities in current demonstration areas received these reports.

The start-up of the demonstration was formally announced through a mailing to nursing home administrators in the test districts. This mailing was followed by meetings with both administrators and directors of nursing, held throughout the demonstration area to further explain the project and to answer questions. A newsletter was sent nationwide to prominent persons and agencies in the long-term care field. In addition, since the reports of knowledgeable media representatives were critical to the public's understanding of the nursing home regulatory system, background sessions were held with press, radio and television representatives. News articles and several recorded segments explaining the project resulted.

Once the project was underway, in the fall of 1978 we refocused our dissemination efforts toward providing information to other states and to our state legislators in order to marshal support for our request to continue the demonstration for a second year. At the end of our first year, requests for information about the demonstration increased. We stirred interest when the demonstration began at its urban Milwaukee site. In addition, we sent an update on the project to over 550 people. This mailing generated requests for specific information about the project--especially from other state health regulatory agencies. States expressing an interest included: New York, Minnesota, Colorado, California, West Virginia, Alabama, Texas, Massachusetts, Tennessee and Kansas.

During our second year, we continued to keep in contact with a variety of groups. Overall the number of requests for information about the project declined. We attributed this decline not to a lessening of interest in the project, but to the fact that it had reached a relatively stable period. We had no requests for information from the media, an indication that implementation of QAP had been accomplished without controversy. Requests from consumers were also fewer. Several of the academic staff of the University of Wisconsin contacted us, including those from the Law School who were interested in long-term care regulation. We responded to requests for information from Canada, Iowa, Florida, Massachusetts, Wyoming, Utah and Maryland.

An increasing number of our contacts were with federal representatives with whom we discussed expansion, Medicare approval and evaluation logistics. Through testimony presented at the Subpart S and Conditions of Participation hearings held in Chicago, QAP methods and experiences were used to support HCFA initiatives to integrate the survey process and to use a sampling of residents during the inspection of care. At the Region's request, the QAP experience was shared at a HCFA-sponsored symposium which addressed the long-term care regulatory role as shared by state survey agencies, health departments and Professional Standards Review Organizations. This exchange at the "Symposium on Integration of Survey and Inspection of Care" provided other states with insight into project methods, and it gave QAP some perspective on long-term care regulation problems in other states.

In June 1980, a local consumer group expressed general concerns about QAP survey procedures. QAP met with two board members and three of the group's staff members to explain QAP procedures and the philosophy behind our screening and sampling methods. Arrangements were made for a member of the consumer group to observe a survey. The group's concerns were allayed by this effort.

During the project's third year, the Wisconsin State Legislature's Joint Committee for Review of Administrative Rules raised some questions about the effectiveness of the State's nursing home regulation system. A special subcommittee on the enforcement of nursing home standards was formed to look into the effectiveness of the mandated state survey process. As background, QAP provided the subcommittee with copies of all its publications. Then on September 30, 1980, Quality Assurance Project surveyors and Bureau of Quality Compliance administrators testified before the subcommittee. Procedures used in both the mandated and QAP surveys and resident assessments were explained. One and a half years later, changes in the state statute were enacted based on extensive subcommittee study.

In response to information requests, we prepared special background materials on QAP for a presentation to the National Governor's Association. We sent the Massachusetts Survey by Exception Project information on how QAP engineers could screen for the Life Safety

Codes. In a special mailing, we brought the nursing home associations up-to-date on our fourth year plans. New York, California, Michigan and Indiana requested information on the project.

In order to inform people of our fourth year changes, we drafted letters to nursing home associations, to advisory nursing home administrators, and to nursing homes in the demonstration districts. We shared our experiences with Massachusetts as they implemented their Survey-by-Exception demonstration. We looked ahead to phasing out and planned for distribution of reports and other information.

Throughout the QAP demonstration, we responded to speaking requests from nursing home associations, professional groups, University of Wisconsin student groups, and at national meetings and conferences. We also opened up our survey process to limited numbers of outside observers. Federal observers, of course, were authorized to observe at any time. To minimize disruption at any facility observed, QAP established general guidelines which we followed whenever scheduling observers for surveys (see Chapter IV, Section D, "Field Observation"). In all, eight federal observers and two consumer advocates watched screening or sampling or both methods being carried out in seven homes around the State.

Contacts during the course of the demonstration are shown in Table 28 and do not reflect distribution of our annual or quarterly reports nor do they include federal Project Officer contacts.

Table 28

Frequency of QAP Information Dissemination
and Public Contacts with Outside Agencies

	YEARS				
	PRE	1	2	3	4
Academic	0	18	22	7	10
Consumer	0	37	15	9	15
Monitoring Planning Agencies	0	52	73	13	47
Media, Legislative, 14 Congressional		23	6	15	15
Providers	*	38	23	17	6
Speeches	11	14	8	11	2
Total	25	183	147	72	72

*Mass mailing



CHAPTER IV

OPERATIONAL COMPONENTS

A. TRAINING

Of all activities which the QAP Field Operations Unit has performed, training is one of the most important and perhaps the most time-consuming. Over the four years of the demonstration this unit has trained surveyors and their supervisors, advisory nursing home administrators, medical review physicians, clerical support staff, consultants and various other bureau personnel.

Surveyor Training

Surveyor training has been an ongoing activity over the years of the demonstration. With the onset of QAP implementation in the rural districts in April 1978, in a subset of urban homes in March 1979, and in the expansion districts in April 1980, surveyors received initial training in the new survey methods. In addition, QAP provided ongoing staff development in a variety of areas to improve surveyor performance in carrying out the new survey methods. As surveyors in demonstration districts left state service, their replacements were also trained.

Training in Rural Districts. The first surveyor training session was conducted in April 1978 in Eau Claire, when the QAP survey approach was first implemented in the three rural districts - La Crosse, Eau Claire and Wisconsin Rapids. The training session lasted one week and included classroom and field experience.

Classroom training took place during the first two of five days and was comprised of new survey method philosophy, including change theory concepts; survey procedures; guidelines for citing deficiencies; three short in-services presenting indices of quality in specific areas; and lastly, instruction and actual practice in conducting strategy sessions. Surveyors separated into teams for the strategy sessions and discussed the first facility in which they would be carrying out a new method survey during the next two days.

On days three and four of training, four survey teams each accompanied by two QAP monitors surveyed four local facilities using the new survey methods. On the fifth day of training survey teams reconvened to discuss their experiences with the surveys, and problems were addressed.

Following the initial training session in the rural districts, QAP held quarterly in-services (July and September). The focus was on further staff development in QAP concepts, particularly the screening and system approaches, and on training in quality areas, stressing key indicators for use in assessing each area.

Overall, the three rural districts received the most QAP training, due to the fact that at that time budget cuts had not created staff shortages. Thus, surveyors had more time available for training sessions.

Urban Training. In March 1979, eight Milwaukee district surveyors were trained in Quality Assurance Project survey methods. The format of this training session was similar to that used for start-up in the rural districts, a one-week session starting with two days of classroom training, followed by two days of field experience and ending with a day of debriefing and discussion.

One innovation at this training event was a strong emphasis on group process skills and communication. The entire second day of the training week was dedicated to this area and led by an outside expert in the field. Emphasis was placed on communication because of its importance in the new survey process where team interaction is a key component. Surveyor response to this part of training was so favorable that the same consultant was scheduled in May 1979 to conduct a similar session with the rural surveyors and supervisors.

Urban training also included a description of field experiences from the rural districts and a panel discussion with state and federal representatives.

Training at Scheduling Meetings. Beginning early in 1979, QAP staff began conducting brief training sessions at monthly district scheduling meetings to update staff in procedure changes and provide additional support as needed. One session involved working with sanitarians to further clarify their role as facility assessment coordinators.

Engineer/Architect Training. In September 1979, following HEW approval for the engineer to screen, the engineer/architect surveyors were trained in the new survey methods. All engineers and architects surveying in the rural and urban districts attended the three-day session. Project staff, the field administrator of the rural districts, and the engineer supervisor acted as trainers and monitors for the sessions. The first day consisted of an introduction to project philosophy and survey methods, explanation of the engineer role, and a preparation and strategy session for the screening surveys scheduled for the following day.

On the second day, the group split into pre-arranged teams to complete the screening surveys in three area nursing homes. Monitors served as facilitators. They assisted the engineers with QAP forms, procedures and answered any questions during the training surveys. Since the surveys were for training purposes only and not to comply with licensure and certification requirements, the nursing homes were notified in advance of our arrival and the purpose of our visit.

On the following day, engineers and QAP staff met to discuss the training and on-site experience. Problems with the process and forms were discussed. While many questions were resolved during the debriefing session, others needed further study by project staff. Answers to these questions were communicated to the engineers at their next monthly meeting.

A representative from the Region V engineering unit (ROFEC) attended a portion of the training session as an observer. This observation permitted him to remain up-to-date on the progress Wisconsin was making and to offer suggestions.

Quarterly In-Services. From September 1979 to June 1980, QAP conducted four in-services for surveyors involved in the project. The first in-service immediately followed engineer training in September. It involved all QAP surveyors from the La Crosse, Eau Claire, Wisconsin Rapids and Milwaukee districts, including the six engineers just trained. It lasted two days and included clerical staff training and staff orientation to the engineer's role in the screening survey. Other topics covered included a screening simulation, exploration of ways to enhance the advisory administrator role, a guest speaker who dealt with nursing home management, and a QAP update. Surveyors and clerical staff responded enthusiastically to the opportunity to meet with all district staff involved in QAP.

The second in-service covered two days in December and again included surveyors from all four demonstration districts. Training session topics included a QAP update, a presentation on health care management by an outside speaker, and discipline meetings. The monthly survey scheduling meeting was also a part of the session which eliminated the need for an extra surveyor meeting.

In February 1980 at the bureau in-service for all state staff, QAP held its third quarterly in-service for QAP surveyors from the rural and urban districts. The project was allotted time at the bureau in-service to meet with QAP surveyors.

Again in June 1980, QAP incorporated its quarterly in-service with the bureau staff meeting. This was the last QAP quarterly in-service as budget cuts and the resulting decrease in staff time made resources for these events impossible.

Training for Expansion. Expansion into the Madison and Green Bay survey districts in April 1980 required a third initial surveyor training session. As previously done, this session took place over a week's time with two days of classroom training, two days of field experience, and a fifth day of debriefing. The Madison and Green Bay surveyors, including engineers, attended. Also included were two new QAP nurse surveyors from the Milwaukee district. Training took place in Madison.

The classroom portion was comprised of presentations on philosophy, screening and sampling techniques, the role of the consultant, team building, and QAP procedures and forms. On-site training took

place over the next three weeks in a nursing home in each district's area with QAP staff or discipline supervisors as monitors.

In August 1980, a two-day debriefing workshop for the expansion districts was held for survey and clerical staff. Survey staff received training in conducting an in-service and were given the opportunity to share their feelings regarding new method surveys. Clerical staff were concurrently debriefed and new staff were trained in QAP procedures. The workshop also involved scheduling surveys and additional discussion about QAP procedures and problems. Problems raised were later responded to via a memo from project staff.

Fourth Year Training. The last surveyor training session which QAP conducted was for changes in the new survey process for the fourth year of the demonstration. In September and October 1981, QAP staff traveled to each of the districts still conducting QAP surveys (Milwaukee, Madison and Green Bay) and met with surveyors for one day. Training centered on a revised citing policy, sampling revisions, and changes to forms and procedures. The strategy and scheduling sessions were also observed and prefaced with a restatement of the procedure for conducting a strategy session.

Follow-up to fourth year training was comprised of survey observations by project staff and the district nurse supervisor.

New Surveyor Training. Throughout the four years of the demonstration new surveyors were added to demonstration districts and required training in QAP survey methods. Before training in QAP methods, surveyors were trained in bureau survey procedures and given time to become familiar with them.

When QAP trained a new surveyor, a project staff person and the surveyor's line supervisor conducted the session. Training included the basis for the project approach and project philosophy, scenario of a new method survey, and details of the facility and resident assessment process and forms. The surveyor was also accompanied by either their supervisor or a project staff person on their first QAP survey.

Supervisor Involvement. Surveyor supervisors have been closely involved in QAP training efforts throughout the duration of the project, especially surveyor training. Project staff communicated training dates, agenda ideas, etc., to supervisors and worked to involve them in training. Surveyor supervisors attended QAP training sessions whenever possible.

In the rural districts, the nurse supervisor took an active role in surveyor training, appearing on the training session agendas numerous times. He also took part in the initial training session for start-up in the urban district. Other supervisors also occasionally took an active part in training, such as participating in panel discussions on various topics.

Supervisors were included in field monitoring of surveyor performance on surveys following start-up on all three occasions. We also solicited their input on training agenda items.

Physician Training

Physicians who participated in the QAP sampling method of resident assessments had previously conducted reviews under the bureau inspection of care process. Project staff initially worked with the group contracted to obtain, orient, train, and schedule physicians for the on-site reviews.

When QAP methods were introduced to the original rural districts in spring of 1978, the project held training sessions at various locations in that area. Physicians were invited to attend, first to solicit suggestions during development and later to orient them to the new resident assessment process.

Just prior to full implementation of sampling in the rural districts, a nine-page training packet was sent to all physicians serving the area. The packet, developed by QAP and distributed by the organization contracted to provide physicians, included: a description of QAP; the role of the physician and how his or her role differed from the bureau resident assessment process; procedures to follow when a new method review was conducted; and copies and descriptions of forms used in the resident assessment process.

In addition to the training packet, the resident assessment team further oriented the physician on-site.

When QAP began in the Milwaukee district, physicians were once again contacted by the group on contract and a training packet was mailed to each of them. There were no orientation sessions held for the physicians however.

With QAP expansion into Green Bay and Madison came a change in communication lines with physicians. The State no longer had a contract with a group that provided physicians but instead contracted directly with just a few physicians. Therefore, the project contacted the involved physicians directly when distributing information and training materials.

Advisory Nursing Home Administrator Training

Training sessions for volunteer administrators were held at least semi-annually. In the beginning, training sessions were scheduled on a more frequent basis as we sought to build up our administrator pool. Two or three sessions were presented on different dates and in different locations during the training month. Table 29 summarizes the training dates, sites and the number of attendees.

Table 29

Attendance of Advisory Nursing Home Administrators
at QAP Training Sessions

<u>Date</u>	<u>Location</u>	<u># of Attendees</u>
<u>1978</u>		
6/7	Wausau	7
6/15	Wauwatosa	7
6/21	La Crosse	3
10/4	Stevens Point	17
10/11	La Crosse	10
11/10	Fond du Lac	10
<u>1979</u>		
1/24	Madison	3
2/28	Madison	11
6/21	Eau Claire	1
6/26	Madison	5
6/28	Fond du Lac	6
10/18	Fond du Lac	13
10/25	Black River Falls	12
<u>1980</u>		
1/29	La Crosse	7
2/28	Milwaukee	14
6/12	Madison	7
6/24	Stevens Point	5
11/6	Black River Falls	17
11/11	Green Bay	17
11/13 (2 sessions)	Milwaukee	36
<u>1981</u>		
6/23	Madison	9
6/30	Stevens Point	11
11/10	Fond du Lac	16

At these sessions, QAP staff covered systems and change theory, team interaction, and the facility assessment process. Data monitoring studies were presented, and we discussed ways to resolve problem situations involving the advisory administrator. An update on QAP activities was always part of the presentation, and often state surveyors were also present to answer any questions the administrators might have.

During all training in 1979 and in June 1980, there was a separate presentation for new trainees and one for those administrators who had been with the project over a year. The two groups then got together and took part in an exercise simulating actual survey situations.

Due to the continued shortage of trained advisory administrators, we began "priority" scheduling of administrators in the fall of 1979. We depended upon field staff to judge which homes could most benefit from an advisory administrator. In April 1980, however, after discussions with the Project Officer, we again set a goal to schedule an administrator for every screening survey. We realized that we must add to our pool of qualified administrators if we were to continue to meet our goal. We began planning a major recruitment effort.

QAP requested permission to attend the various association meetings scheduled to be held in October. We attended the convention of the Wisconsin Association of Nursing Homes (WANH). QAP staff and a nursing home administrator active in the project joined forces to deliver a presentation and to urge association members to sign up for the November training sessions. Prior to the meeting, an association officer made some personal recruitment appeals. We made a similar presentation at the convention of the Wisconsin Association of County Homes (WACH). Again an association member, active as an advisory administrator, aided in recruitment. As a follow-up, Wisconsin Association of Homes for the Aging (WAHA) and WANH newsletters printed our news releases about the need for advisory nursing home administrators in the Quality Assurance Project.

This effort resulted in 43 new administrators attending the November training sessions in addition to 27 retrainees. Of the 43, 36 met all requirements and were eligible to participate in the project. This recruitment brought the total of advisory administrators to 86, almost doubling our "pool".

The November 1980 training session also marked a revision in the training format. In the past, QAP staff had divided recruits from retrainees and held separate sessions with each group. This time both retrainees and new recruits were intermingled in small groups. The retrainees lent some of their expertise and experience to the new recruits.

Two update training sessions for advisory nursing home administrators were held in June 1981 which 20 administrators attended. Since our recruitment efforts for the November 1980 session were so successful, we made no attempt to recruit new administrators at this time, but concentrated our efforts on updating administrators currently participating in the project.

The training session held in November 1981 also differed from the norm in that it was a one-session event with limited attendance. With the project in its fourth and final year, we assessed our needs for the coming months, and, from the list of those due for training, selected administrators with good participation records and good ratings.

As of the end of the project, we had 40 administrators eligible for participation.

B. PROCEDURE MANUAL AND FORMS DEVELOPMENT

Development of the Procedure Manual

Our first Screening Survey Manual (SSM) was distributed to field staff in November 1978. The manual consisted of three parts. Part I contained the projects' policies and procedures in "playscript" format. Part II listed resources available to field staff. This included a list of consultants within the Bureau and other state consultants in the areas of geriatric care and developmental disabilities. A bibliography of long-term care literature was also provided. Part III included an explanation of the survey process, responsibilities of all team members and QAP forms and completion instructions. Two additional sections, Parts IV and V, were not ready for distribution until the first revision in March 1979.

The manual revisions completed in March 1979 were timed to coincide with our first major revision to the screening and sampling forms. In addition to major revisions to Part III, we completed Parts IV and V. Part IV listed follow-up actions taken by surveyors as a result of a new method survey and documentation requirements for each action. Part V explained inter-office procedures.

In March 1980, another revision to the manual was made. The main reason for this revision was an extensive revision of the survey forms. A questionnaire was sent to all QAP surveyors and supervisors to solicit feedback regarding the usefulness of the current manual and their ideas for change.

In this revision, the format was simplified and the layout reorganized. Section I included a scenario and forms grid for each of the three QAP treatment cells. Section II contained responsibilities for all team members. Section III contained all survey forms and completion instructions. Section IV contained inter-office procedures. An appendix was added which included the selection process for the advisory nursing home administrator and the physician training packet.

Our final revisions to the manual were completed in January and March 1982. The revision completed in January reflected changes made by the project for the final year of the demonstration and also recent bureau changes affecting project operations. Specific sections revised included: the survey scenario, modifications to the sampling process, changes in the project's citing policy, how sampling interfaced with the bureau inspection of care process, key forms revisions and changes in forms distribution.

A comprehensive revision of the Screening Survey Manual was completed in March 1982. While no procedural changes were made after the January distribution, this final revision was necessary to bring the entire Procedure Manual completely up-to-date.

Forms Development

The facility screening and resident assessment tools were developed by Wisconsin experts in long-term care from regulatory agencies, academia, and the health care professions.

The facility assessment screening tool was designed for surveyors to use to quickly screen a home in selected care areas and to pinpoint those areas in which the home was experiencing problems. A seven-page facility assessment form was developed and field tested in March 1978. Care areas included Resident Condition, Resident/Staff Relationships, Dietary, Facility Appearance/Environment, Recreational Activities, Resident Community Activities, Facility Safety, Care Management, Special Resident Population, Staff, Professional Ties, Management, and Philosophy. A face sheet was also developed that listed facility staff, names of surveyors who completed the survey and space for surveyors to briefly indicate the status of each care area (see Attachment 36).

The resident assessment tool was developed to enable surveyors to complete an in-depth review of a sample of residents and determine if the various care systems within the facility were meeting resident needs. The two-page resident assessment form was developed in March 1978. The forms included space for both disciplines to document their interviews with the resident and facility staff. Sixteen care areas were identified and the assessment team was asked to rate the quality of care provided for each resident in each area. The resident assessment forms also included the Level of Care Performance Evaluation form that was used to determine if further sampling or the inspection of care was necessary (see Attachment 37) and a face sheet which listed the names of the assessment team, the status of each resident care area and level of care data.

The Summary of Findings form was developed for surveyors to report overall problem areas found on the survey and to recommend corrective action and completion date. The facility representative was asked to document what action would be taken and when the problem would be resolved (see Attachment 20). The Special Advisors Findings form was developed for advisors to document survey findings and report their recommendation to the survey team (see Attachment 38). Forms were also developed for surveyors to complete to evaluate the effectiveness of consultation (see Attachment 39). An evaluation of the entire survey method was developed for the facility to complete (see Attachment 40).

Our first major forms revision took place in March 1979. On the facility assessment tool, the number of facility care areas were collapsed from thirteen to ten and the number of pages reduced from seven to five. The content of the form remained the same. The resident assessment forms were redesigned to allow more space for interview information and included a section for a team assessment by the nurse and social worker (see Attachment 41). A separate form

for the physician to document his/her assessment was developed by the physician on QAP's Advisory Panel. The face sheet was redesigned to combine information from both the resident and facility assessments, and a consultation form was developed for surveyor use. A Facility Assessment Composite was printed for surveyors to combine their individual reports during the pre-exit conference to present an overall assessment of the facility at the exit conference.

At approximately the same time, surveyors asked QAP to develop explanatory statements of the survey process that could be given to the facility at the entrance conference. Three introductions were written; one for each QAP survey combination.

Our forms were again revised in October 1979. Various revisions were made to the design of the forms; no changes were made in content.

A final revision to the resident assessment forms was completed in November 1981. Early in 1981, through survey observation and discussions with field staff, QAP staff identified the need for more specific guidelines for assessing quality in the resident assessment process. Several surveyors indicated that the QAP forms were too vague and open-ended. At this same time, the Bureau saw the need to refocus the inspection of care process on its primary goal of assessing the quality of care rather than the current emphasis on care level.

As a result, a nurse consultant with the University of Wisconsin, was hired to facilitate a re-evaluation and development of the quality of care assessment. A panel, composed of seven bureau staff persons, a physician and a nursing home Director of Nursing, developed a list of "proximal cues" or key indicators to use when assessing quality of resident care. Of this list, the group then chose seven key indicators seen as most important. Other items were noted as important, but the panel felt that staff training was needed before these criteria could be applied consistently throughout the State.

QAP staff then met individually with each panel member to discuss how to investigate each of the seven key indicators and to determine what nursing home systems were involved. A compilation of these items were listed on the QAP assessment forms (see Attachment 42).

The Level of Care Performance Evaluation form was also revised (see Attachment 9). It reflected the revised sampling plan implemented at the beginning of the fourth project year.

Our Facility Assessment forms were again revised in 1981, but no changes were made in content (see Attachment 15).

C. SCHEDULING

Survey/Surveyor Scheduling

For the Quality Assurance Project, scheduling efforts have focused on training field staff in the QAP scheduling forms, strategy session, and procedures; coordination of QAP scheduling with other sections of the Bureau; and monitoring and refinement of the scheduling process.

Scheduling Philosophy. One main premise of the project was to reallocate the amount of time spent in each home based on the home's history. If a home had a history of providing poor care or non-compliance with state and federal codes or was unable to accurately set care levels, the project stressed that more time should be spent in surveying the home and greater effort expended in ongoing monitoring of the home's progress toward correction. In the same vein, homes that have demonstrated the ability to provide good care and are able to accurately set care levels, should require less monitoring by the Bureau. This idea differed greatly from the Bureau's scheduling plan where time allotted for survey was based on the size of the facility and number of residents.

The project realized that the variety of factors to consider when making these determinations were complex, and special emphasis would have to be placed on the scheduling process.

Scheduling Meetings. Prior to QAP, surveyors met every month in each district office to plan the workload for the following month. These meetings were brief and consisted of determining which surveyors were responsible for completing the survey in each facility. All survey dates were scheduled individually by surveyors; no formal attempt was made by the Bureau to coordinate surveyor visits in the facility beyond the requirement that they "exit" at approximately the same time.

In order to plan for and complete the new method surveys, the monthly scheduling meeting was expanded. It included a strategy session for each home to decide whether screening and/or sampling would be used (see Chapter II, Section A for a description of the strategy session), and consecutive survey dates were scheduled when all surveyors could be in the facility together. In mid-1979, strategy session guidelines were established and distributed for field staff use (see Attachment 2).

Since the QAP scheduling requirements were much more complex than the Bureau's, it became necessary to appoint a scheduling coordinator. The coordinator role was rotated among all surveyors on a monthly basis.

Finite Scheduling Document and QAP Survey Schedule. For the first two months of project implementation in 1978, the project's Field Administrator would call project staff and communicate the results

of the scheduling meetings in each of the districts. As this method of communication proved ineffective, QAP staff developed the Finite Scheduling Document (FSD) for field staff to use to inform central office of survey decisions.

One document was submitted for each home eligible for a QAP survey. The scheduling coordinator indicated the survey type and dates, resident and facility coordinator, name of physician scheduled, names of any special advisors and date the advisory nursing home administrator was needed.

Based on the information submitted on the FSD, QAP compiled a monthly schedule of all QAP homes (see Attachment 43) and sent copies to bureau staff affected by the facility schedule. A copy was also sent to our representative at the regional office in Chicago.

In 1979, the FSD was revised (see Attachment 44) to specify type of expertise needed by the advisory administrator and to indicate if a surprise survey was scheduled. Space was also added for the home's level of care history.

After a year's experience with scheduling, we documented our scheduling procedures in an internal procedure manual. In addition, procedures were developed for emergency scheduling situations, such as surveyor illness and cancellation of a special advisor.

QAP Attendance at Monthly Scheduling Meetings. From the beginning of the project, QAP staff used the bureau's monthly scheduling meetings as a means of communicating with surveyors and supervisors and to monitor the progress of the project. In the rural districts, project staff attended several scheduling meetings to monitor strategy sessions and to explain form and procedural changes. When the project expanded into the urban district, the nurse supervisor was not able to serve as project field administrator as had been the case in the rural districts. As a result, QAP appointed a staff person as field monitor to serve as liaison to the project. Our field monitor attended all scheduling meetings and used these meetings as mini-training sessions. Scheduling meetings proved a useful means to keep in touch with surveyor acceptance of the methods and to monitor progress and identify areas of concern.

When the project began in the expansion districts, both nurse supervisors took an active role in project implementation. A QAP staff person was assigned to each district to act as a project representative. They attended all scheduling meetings to monitor strategy sessions, facilitate scheduling, identify problems and update QAP surveyors on procedural changes.

Implementation of QAP Scheduling by the Bureau. In April 1981, after three years of testing project methods, the rural districts returned to the full survey and inspection of care for all homes. The Bureau took this opportunity to pilot test QAP scheduling components for possible statewide implementation (see Attachment 45). These districts were chosen as they were familiar with the process. With the nurse supervisor acting as scheduling coordinator, all survey dates were set prior to the scheduling meeting to ensure team surveys. The facility survey was scheduled immediately after the inspection of care. Surveyors were asked to complete a file review for all homes assigned to them and to be prepared to discuss survey strategy. Scheduling documents listing the names of surveyors assigned to the facility and all survey dates were also submitted to the central office scheduling coordinator.

Scheduling Advisory Nursing Home Administrators

Surveyors indicated on the Finite Scheduling Document (FSD) the date the advisory nursing home administrator was needed and the priority the surveyors placed upon that need. The FSD was then sent to the QAP office. QAP staff made the needed arrangements and returned a copy of the FSD to the coordinator with all information regarding the advisory administrator scheduled.

When scheduling an administrator, consideration was given to travel distance, the advisory administrator's own survey month, restrictions set by the administrator (such as a possible conflict of interest), and area of expertise required. Originally, we tried to match by association also but found this was not feasible. We did attempt to match a county administrator with a county home since we felt a special type of expertise was needed. We also took into account the size and type of home.

The administrator was contacted by a QAP staff person by phone, approximately three to four weeks prior to the survey. He or she was informed as to the date of the survey, travel distance, district of survey, and the name of the team coordinator who would be contacting him or her three to five days before the survey. The phone call was followed up with a letter confirming the survey date, along with information on the role of the advisory administrator, reimbursement forms, and explanations (see Attachments 46). Also, if the administrator was participating in a survey for the first time, he or she was reminded that Chapter 50, Wisconsin Statutes prohibits disclosing the date of the survey.

The team coordinator would call the advisory administrator three to five working days before the survey and relay the name of the facility, its location, and schedule a time and place to meet.

A special data study was done in 1980 to assess the use of the advisory administrator on the survey team. Two attitude questionnaires, one for administrators and one for surveyors, were developed and implemented (see Attachment 47). The results of the three-month period from April through June 1980 are reported in Chapter II, Section E.

Scheduling Review Physicians

At the onset of the demonstration a physician was scheduled for all resident assessments in all Medicaid certified facilities, including ICF-only. This procedure was in contrast to the federal requirement that physicians conduct reviews on SNF residents in SNF certified homes only. QAP's option to use physicians in any ICF-only home was a change from the usual bureau procedure.

When the project began in the rural districts, physicians were scheduled for the second day of the resident assessment process. They were allowed approximately three hours to review the average sample of ten residents, and for larger samples the amount of time was increased.

On October 1, 1979, due to changes in federal regulations, the Bureau began scheduling medical review physicians on a selective basis. Guidelines were developed for use in making the decision on whether a physician should be scheduled. QAP surveyors also followed these guidelines and discussed the need for physician involvement at their monthly scheduling meetings. Optional scheduling of the physician resulted in a severe decline in their use in the inspection of care process, both in QAP and non-QAP nursing homes.

D. PERFORMANCE MONITORING

Documentation Review Procedures

QAP monitoring began in 1978 as the project started up in the La Crosse, Eau Claire, and Wisconsin Rapids districts. In March of 1979 we began monitoring the portion of Milwaukee district homes added to the project. It was important to monitor all paper reports generated by the QAP survey process and extract data which we used not only for our own internal analysis but also in anticipation of the upcoming outside evaluation.

Expansion into Madison and Green Bay (135 homes) occurred in April 1980. In preparation for that expansion, QAP staff trained bureau reviewers in our report monitoring systems in January 1980. The bureau reviewers assumed responsibility for the rural districts, and we concentrated our efforts on the Milwaukee, Madison and Green Bay districts. Bureau reviewers also received an update training session in April 1980.

QAP reports were routinely monitored for completeness and quality of documentation (see Attachment 48 for a stepwise summary of report logging procedures). In the course of this monitoring, problems emerged which required solutions. In some instances, more specific guidelines were established for survey forms completion. Other problems were resolved by changes in forms and/or procedures. Sometimes a simple explanation sufficed.

Each surveyor submitted a facility assessment worksheet noting problems found during the survey. Project staff verified that any problems identified on these worksheets were transferred to either the Facility Assessment Composite or the Summary of Findings sheet.

The resident assessment forms were also reviewed. Any major problems not satisfactorily concluded on individual assessments had to be transferred to the Summary of Findings form.

The initial review consisted of checking the Summary of Findings (SOF) sheets for optional follow-up actions that surveyors planned to take in addition to citing. These actions included consultation, investigate further, and return to verify. To track these follow-up actions, a card file was set up. The actions were recorded on the "Action Tracking Card", with the proposed date of surveyor return indicated (see Attachment 49). The cards were checked weekly for late items. (A one-month leeway was given to allow adequate time for report writing, mailing time, etc.) Surveyors were reminded of late items through sending of the "Pending Action" form (see Attachment 49).

When the follow-up Summary of Findings indicated the problem had been resolved, the Action Tracking card was noted "NFA" (no further action), and placed in the inactive file.

The second review was a much more in-depth review and was designed to check for completeness, quality of documentation, and appropriateness and timeliness of state action. We determined if all unresolved problems and trends indicated on the Resident Assessment Team form have been transferred to the Summary of Findings. We evaluated the documentation of each problem area noted on the Summary of Findings, checking that evidence was included on the magnitude of the problem, possible source, and its impact on resident care.

The SOF was also checked to make sure the state action prescribed for a problem was appropriate and was completed within an acceptable time frame. For problems identified as having direct impact on resident care, follow-up was to be completed within 30 days of the survey exit date. For problems identified as having an indirect impact on resident care, follow-up was to be completed within 60 days. Follow-up dates could be extended to 90 or 120 days for problems requiring extended correction time. A benchmark date of 60 days was established, and either onsite or telephone contact was made to verify that the facility was in the process of correcting.

Originally it had been acceptable to document state Class C violations (with the exception of staffing deficiencies) on a Summary of Findings if the violations did not seriously affect the health and welfare of resident care; it was also acceptable to choose an alternate action, in place of citing, to correct the problem. In October 1981, QAP was directed by the Bureau to adhere to the Bureau's state code citing policy. Any state code violation documented on a Summary of Findings form had to be accompanied by a Notice of Violation (NOV).

To provide an overall picture of facility quality, a grid was used (see Attachment 50). Problems were listed; checks (✓) were used to indicate where a problem was identified (Facility Assessment Composite, Summary of Findings or Resident Assessment forms), and whether the impact, magnitude and source of the problem was given. The previous year's survey was also checked to detect any repeat problems.

If we considered a state action inappropriate or if any other problem emerged in the course of the review, the surveyor or line supervisor was contacted. (Any major concerns were first brought to the attention of the QAP Chief of Field Operations. The matter was discussed and a course of action decided upon.)

QAP began utilizing the Long-Term Care (LTC) Survey Log Receipt to provide additional feedback to Madison and Green Bay surveyors. The comments have focused on quality of documentation, choice of alternate action, or any other aspect that merits commendation (see Attachment 51).

Problem Homes. Another facet of QAP documentation monitoring used throughout the project was the problem homes work-up. This work-up consisted of checking annual and interim surveys, listing problems found and actions prescribed for those problems by state surveyors. Depending on the severity and the number of problems found in the most current survey, it could be necessary to check back into two or even three years of survey information.

Originally these work-ups were done after problems had already reached a "crisis" stage. However, we realized we needed procedures to recognize potential problems so that we could take action to prevent an actual occurrence. In early 1979 a QAP administrative staff person began attending the Bureau's Problem Facilities meetings. Prior to the meeting, QAP staff held their own "pre-problem homes" meeting and discussed homes due for survey. Areas of discussion included: number and class of NOV's number and nature of complaints, other problem areas identified but not cited, repeat problem areas, etc. Information on those potential problem homes was relayed to the bureau meeting attendees for discussion. If deemed necessary, a course of action was decided upon.

Attendance by QAP at the Problem Facilities meetings was discontinued in early 1982, but we continued to review the meeting notes to keep current on developments.

(See Attachment 52 for an example of a sample problem home work-up.)

Rural Post-Monitoring. In April 1981, homes in the rural districts returned to the mandated survey methods after having been surveyed by QAP for three years. This switch necessitated the development of new review procedures. The following procedures were set up to compare results of the mandated survey with the preceding QAP survey:

- compared this year's survey with the previous QAP survey
- starred homes with 1 or more Class A or B, or 15 or more Class C and federal violations
- review the notices of violation (NOV) from the most recent survey of the starred facilities
- if most recent survey NOV's indicate problems which impact on resident care, will review last year's survey results for repeats, actions taken, general findings under QAP survey method
- routed comparison to Field Operations staff for review.
- after reviewing starred homes, will discuss which facilities should be referred for possible inclusion on the Problem Facilities Meeting agenda.

Documentation Review Interface Between QAP and the Bureau of Quality Compliance

Although project staff conducted their own documentation review of QAP survey packets, there was also a documentation review interface between the project and the Bureau of Quality Compliance. Once project staff had completed their review of the documents, the documents were forwarded to appropriate bureau staff for further processing. The timeline described below reflects this interface.

- | | |
|---------------|--|
| Day 1 | Received in QAP office. Packet checked for completeness. QAP retains copies of Screening Assessment Facesheet, Facility Assessment Composite, and Summary of Findings. Any data required from bureau forms for QAP studies is extracted before routing to Long-Term Care (LTC) clerk. |
| Day 1 | LTC clerk receives survey packet. Sends out LTC Survey Log Receipt to surveyors. Extracts resident assessment data for Quarterly Showing, and Medicaid inspection of care data for master survey schedule update. Logs in information (surveyor name, date received) on H-32 Survey Log. Routes to Facilities Regulation Section (FRS). |
| Day 1
to 5 | FRS reviewer compares NOV's issued with the Single Survey Instrument (SSI) to ensure that all federal deficiencies have been cited, that classifications of state violations are proper, that all problem areas are addressed and that codes cited are accurate for the violation as documented. Reviewer approves, amends, or imposes Plan of Correction (POC). |
| Day 6 | Survey packet is routed to event tracking for updating the event tracking system (ETS) log sheet and the 8100 computer card file. |
| Day 6 | FRS program assistant issues letter to facility indicating reviewer determination on P.O.C. and establishing verification visit deadlines. (Last day of 2nd following month) |

Approximately 30 days prior to expiration date of provider agreement, FRS reviewer reviews verification visit reports. Certification and Transmittal form (C&T) is issued with letter recommending approval of new provider agreement for facilities in compliance.

Field Observation

One method used by the project to evaluate the effectiveness of QAP was to observe new method surveys. QAP staff used these observations to critique the survey methods, get immediate feedback from surveyors regarding the methods, and to answer surveyors' questions regarding the methods.

Survey observations were scheduled on a routine basis but intensified when special needs arose. All field staff training sessions included an on-site survey as a part of the training. As soon as possible after a training session, project staff would observe surveyors on new method surveys to assist in implementation and answer questions regarding the forms and procedures.

Surveyor supervisors also periodically observed new method surveys. They monitored on-site surveys used for QAP training in their respective districts. They also followed up by monitoring one to two surveys in their districts after training was completed. The nurse supervisor in the rural districts had been designated a QAP Field Administrator due to his involvement in project development and philosophy, and he took an active role in observing QAP surveys and identifying problems as they arose in the field.

Several changes in project procedures were made as a result of these field observations and feedback received from surveyors. In 1979, QAP staff observed a N/N survey in the rural districts. As a result of the observation, the project allowed the scheduling of two social workers on all N/N surveys. In addition, the amount of time scheduled for the screening survey was made more flexible depending on the size of the home and distance from the district office. In 1981, several survey observations and feedback from surveyors and supervisors led QAP to review the advantages and disadvantages of the two-team approach in the N/N survey cell and ultimately led to revision of the survey scenario in the fourth year (see Chapter II, Section B).

In 1981, QAP staff developed a survey observation report form (see Attachment 53) designed to identify problems, critique survey technique and determine areas needing further training.

The Quality Assurance Project received a great deal of attention from many quarters since it began in April 1978. This interest resulted in requests to observe surveys. Those requesting to observe surveys came from various groups: federal representatives from HSS in Washington, D.C., federal representatives from Region V in Chicago, members of consumer organizations, and bureau staff.

Since one concept of QAP was the team approach, the home was already faced with the entry of a large group of people. Scheduling of observers, therefore, necessitated specific guidelines and procedures.* QAP staff, with input from field staff, developed the following procedures:

1. QAP would send surveyors a list of facilities eligible to receive new method surveys. We then asked surveyors to indicate in which facilities observers would be inappropriate.
2. Working with the above list, QAP tentatively scheduled survey observations. The team coordinator was always contacted prior to the survey to determine if the survey was still appropriate for observation.
3. QAP staff sent the team coordinator a written statement about the observer and the purpose of the observation.
4. QAP staff described the survey process to the observer before the survey in order to minimize disruptive questions during the survey.
5. QAP provided the observer with a name tag.
6. QAP asked the observer to comment in writing on the observed survey, and we sent a copy of this report to the survey team (see Attachment 54).

*Federal staff were authorized to observe any survey they chose.

CHAPTER V

CONCLUSIONS AND IMPLICATIONS

On the whole, QAP components as originally envisioned were moderately well implemented. However, anticipated outcomes occurred only in part. Although we did not achieve in total what we had hoped, we did find some unanticipated benefits.

Facility screening was the component least fully implemented. In the judgment of project staff, facility screening as proposed was minimally carried out by all surveyor disciplines - nurses, social workers, sanitarians and engineers. We believe individual surveyors were able to use the facility screening methods as proposed. However, it was difficult for many surveyors to utilize a fundamentally new process which required them to switch from a code compliance headset to screening for outcomes and making quality determinations. Some surveyors apparently tended to use their own key indicators drawn heavily from the 1,500 plus regulations for which they normally check. In addition, very few engineers actually screened for the Life Safety Codes, in part due to the conditions placed on engineer screening in order to obtain the waivers from HCFA. Ultimately these restrictions meant that the engineers still had to complete the Life Safety Code portion of the survey.

Resident sampling was fully implemented and appears to have been over used. The majority of homes received and passed the sample. We did not anticipate, for some reason, the element of human psychology entering into sampling. In the demonstration, surveyors not only made the judgments on individuals' care levels in the sample, but also knew the pass/fail criteria. Data suggests that surveyors' judgments were influenced by this prior knowledge. Other factors, such as good quality of care, which does not necessarily correlate with the numbers of incorrect care levels, also may have prompted the surveyors to pass the sample.

The goal of achieving time reallocation was partially met. While QAP surveyors reallocated time from good to problem homes, non-QAP surveyors reallocated as much or more time than QAP surveyors. Contrary to QAP's hypothesis, QAP surveyors spent less, not equal, total time in homes of all quality.

QAP surveyors used more total follow-up actions than non-QAP surveyors as predicted. Surveyors relied primarily on consultation and verification activities. The number and range of these actions declined over time, and verification activities had become the key action by the end of the project.

During the first three years of the project, QAP surveyors exercised the option to utilize other corrective actions besides citing when they found problems that did not directly threaten resident well-being. Fewer non-serious violations/deficiencies were cited in QAP homes as compared to non-QAP homes. However, equal numbers of serious violations/deficiencies were cited.

At the beginning of the fourth year, the project revised its citing policy on violations of state codes and instructed surveyors to cite all observed violations. However, surveyors still had the option of using alternate actions to citing when they found deficiencies on federal codes so long as the problem did not directly threaten resident well-being. As a result, surveyors began to cite more non-serious state Class C violations but continued to use alternate actions on non-serious federal deficiencies.

The inclusion of a practicing nursing home administrator was felt beneficial by both surveyors and volunteer administrators. The advisory administrator provided valuable administrative and management skills to the survey team. However, field observations by QAP staff suggested a need to further enhance communication between the advisory administrator and the team, should this component of QAP be retained by the Bureau of Quality Compliance.

What we ultimately expected to demonstrate - improved quality of care in QAP homes - did not occur. What we found instead were no differences between QAP and non-QAP homes in compliance with regulations, in frequency of repeated problems and violations, and in overall Medicaid reimbursement to nursing homes. Yet QAP methods saved time and used alternative methods to citing to correct problems. Thus, although we were not able to improve quality of care with a reallocation of existing resources, we did demonstrate that through QAP methods, fewer resources could be used to achieve an equal level of quality of care in nursing homes.

It is useful to examine what potentially caused the outcomes to be different from what we anticipated. With the knowledge of hindsight, we can hopefully shed some light on the barriers and difficulties we encountered, thus making our experience useful to others who may be planning to implement or test similar methods.

We divide the causes into three general sources--operational, philosophical/conceptual, and educational. There were three operational problems. First--"demonstration strain"--having four cells, running four years and having the control methods change more often than the demonstration methods, took its toll. Second, the project's administration was outside bureau lines which added to the "experiment" headset. Therefore, bureau staff in general were less likely to regard the methods as accepted practice. Third, our internal monitoring of project operations was too limited. Our rapid expansion into additional districts after start-up led us to focus heavily on training and implementation preparation and not enough on monitoring outcomes in the field. It took some time before we realized how complex the problems in implementation were, and then we did not have the resources to resolve them. In addition, it was not until the last year of the project that our internal data studies began to clearly document incomplete implementation of the methods, e.g., the study of surveyor time allocation.

There were two primary philosophical/conceptual causes. First, there was a psychological barrier to using alternate actions to citing. Surveyors knew QAP was a demonstration which was testing an unproved

process which, technically, was not in keeping with state statutes since it permitted alternate actions to citing of state codes if the problem was not directly threatening to resident health and safety. Since nursing home residents are a vulnerable population whose welfare surveyors are charged to protect, surveyors may have been uncomfortable fully implementing methods which might fail.

Second, in 1980 a special legislative committee was formed to study nursing home enforcement in light of media criticisms of the State's enforcement process. Although there was no criticism of QAP directly, clarification of state statutory requirements at about this same time led eventually to a change in QAP's policy on citing state code during the fourth project year. The legislative committee's deliberations may have caused more "conservative" surveyor behavior and lessened surveyor opportunity and motivation to use alternate actions even prior to the fourth year changes.

There were two educational causes. First, we underestimated how big a transition it would be for surveyors to switch from checking codes to screening. Second, surveyor training was not carried out as originally planned due to a lack of resources.

In spite of these difficulties, there were unanticipated benefits. One side benefit accrued through QAP was the mirror it held up to Wisconsin's ongoing survey process. It was helpful to know that the existing nursing home regulation system is effective at problem detection and lasting problem correction. Data collected during the demonstration by QAP and by the independent evaluator suggest that both QAP and the ongoing process are working well and are about equal in their outcomes. At the same time, the close scrutiny provided the Bureau with valuable feedback used to reorganize and amend some intrinsic, internal problems (such as team functioning and supervision) that will benefit any methods chosen.

Many of the QAP concepts which do not require waivers or regulation changes have been implemented or are scheduled for adoption by the Bureau of Quality Compliance. The Bureau has or is ready to implement:

- strategy sessions;
- tighter, team scheduling;
- in-depth resident reviews, for a subset of all Medicaid recipients in a facility, and standard reviews for all remaining Medicaid residents;
- multi-disciplinary team problem solving.

The Bureau is also considering future use of the advisory nursing home administrator.

In addition, QAP's experience in the following areas may be useful if regulatory agency budget reductions continue:

- problem facility identification;
- screening;
- sampling.

As for the future of the methods, three of the components which QAP tested cannot be adopted without federal regulatory change or waivers--screening, sampling, and alternate actions to citing. Alternate actions to citing also require a change in state codes. Of these methods, in-depth assessments of a sample of residents, which was more fully tested, seems to hold the most potential as a flexible and creative method of review. Based on experience gained during the demonstration, we believe it would be possible to devise a sampling strategy that both saves time and overcomes the surveyor bias which QAP found.

In January 1982, Wisconsin requested of the federal Department of Health and Human Services (HHS) approval of waivers under Section 1915(b) of the Social Security Act that would enable screening and sampling statewide. That proposal was based on our experience with QAP and specified full surveys and inspections of care every two years, with the option to use a QAP approach (screening, sampling or full review as indicated by the homes' compliance record) in between the full inspections.

The request was not approved, as HHS determined the Wisconsin proposal was outside the authority given the Secretary in Section 1915(b). The inability to obtain other statewide waivers or enabling regulation changes at this time offers us a chance to take stock of the quickly changing regulatory atmosphere and determine where QAP experiences can best enable Wisconsin to cope with budget reductions, increased workload and evolving long-term care philosophies.

We highlight three areas which Wisconsin will continue to ponder.

Screening. Federal requirements specify that nursing homes be checked annually (Medicare requirements did change in the project's fourth year) for compliance with all conditions of participation. We proposed, but were only partially successful in implementing, use of a form listing quality criteria that had no direct ties to state codes or to the federal conditions of participation and often called for subjective "outcome" assessments.

In comparing the methods, we saw no difference between the methods in (1) frequency of serious Class A and B violations cited, (2) frequency of federal conditions and standards cited, (3) no deterioration in compliance after three years of screening, and (4) no greater frequency of recurrent problems from one year to the next. However, since we believe screening was never fully implemented, this leads us to speculate whether screening might yet provide a superior approach to problem identification than the required full survey.

Sampling. Annual on-site inspection of each Medicaid nursing home resident is federally required. We fully demonstrated two sampling approaches, both based on random selection of all residents in a facility. We learned that as regards the level of care determination (which impacts on reimbursement), more homes than would be expected passed the sample review. Overall, however, this did not result in higher reimbursement for QAP homes, and after 3 years of sampling, there was no difference in percent of incorrect care levels in QAP homes as

compared to homes which had received an inspection of care. Sampling for level of care, we conclude, is a possibility, but we would add that the element of surveyor judgment--and possibly method of selecting residents for review--be reconsidered prior to any future implementation.

Analysis of the ability of sampling to accurately assess quality of care is, of course, far less quantitative. Again, there was no difference between the sample versus full review methods in identifying problems which directly threaten resident health and safety. However, there are philosophical issues of advocacy for each and every Medicaid resident which need to be resolved.

Targeting. The demonstration philosophy was peppered with options and alternate sanctions which relied heavily on professional judgment and surveyor discretion. We learned that while many surveyors liked QAP better than the mandated process, the expected outcomes of time reallocation and use of alternate actions were not observed.

QAP surveyors did not reallocate all of their time saved in "good" and "average" homes to activities in "problem" homes. Had the feedback been there to encourage surveyors to reallocate, the results may have been different. Perhaps if QAP had carried out more timely data collection and on-site monitoring of surveyor performance from a statewide perspective to create the needed feedback, reallocation might have occurred as proposed.

Surveyors might also have been able to use a wider range of more creative actions if additional training had been provided. For example, some surveyors lacked the experience and/or skills needed to provide formal inservice and consultation to a facility. Various project inservices did focus on these areas, but surveyor feedback and project staff assessment indicated that additional and more specific training would have been beneficial.

Also, many bureau staff members did not provide the necessary feedback and support needed to reinforce the validity of alternate actions. Over the course of the demonstration, the number of consultants available to support surveyors dropped radically, further reducing the State's ability to target problem nursing homes.

In addition, nursing home administrators who received the QAP method inspection in their facilities did not respond to the incentives for less disruption by the state survey process. They did not upgrade the quality of care, reduce occurrence of repeat problems, or improve the accuracy of resident levels of care in their nursing home. The results of QAP data studies, again, were too late to press for more "good faith" improvement efforts by facilities. Had QAP carried out more timely monitoring of nursing home performance from a statewide perspective and provided needed feedback, upgrading of quality of care might have occurred more as proposed.

In looking back over the demonstration experience, we are convinced the concepts offer potential for further exploration and study. We have found the forum for self-examination both illuminating and helpful in this time of proposed change in approach to nursing home regulation.

LIST OF ATTACHMENTS

1. Glossary of Terms Pertinent to the Quality Assurance Project
2. Strategy Session Guidelines
3. Guidelines for Surprise Surveys
4. Core Criteria that May Mandate a Full Survey or Full IOC
5. Quality Assurance Project/Introduction to the New Process
6. Level of Care Performance Evaluation Sheet; 1/1980
7. Procedure for Updating Level of Care Histories
8. Revising the 10% Sample for Resident Assessment - History and Rationale
9. Level of Care Performance Evaluation Sheet; 9/1981
10. Resident Assessment - MD
11. An Analysis of the Effect of Wisconsin's Inspection of Care Reviews on Medicaid Nursing Home Reimbursement: A Comparison of the Quality Assurance Project Approach and the Federally Mandated Approach
12. Further Analysis of Wisconsin's Nursing Home Inspection of Care Reviews
13. Further Analysis of the Effects of Sampling
14. Facility Assessment Worksheet
15. Facility Assessment Composite
16. Volunteer Nursing Home Administrator Participation Agreement
17. Nursing Home Administrator File Checks/An Update on Criteria
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19. Monthly Summaries of Participation by Advisory Nursing Home Administrators
20. Summary of Findings Form
21. Previous Published Reports of the Quality Assurance Project

22. Region V Request for Documentation
23. Documents Related to Pre-Waiver Homes
24. Region V Approval of Certification of Pre-Waiver Homes
25. Revised Reporting Plan for the Quarterly Showing
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27. Facility Environment Information Form
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29. Role of the Engineer in Quality Assurance Project Screening Survey
30. Region V Approval of Role of the Engineer in Facility Screening
31. Present Documentation Requirements for Medicaid - Medicare Recertification Used by the Bureau of Quality Compliance (Non-QAP)
32. Sample Response Letter to Federal Validation Survey
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ATTACHMENT 1

Glossary of Terms
Pertinent to the Quality Assurance Project

Advisory Nursing Home Administrator. Active or practicing nursing home administrator, recommended by a nursing home association, who voluntarily serves as an advisor on the QAP survey team.

Bureau of Evaluation (BOE). A sub-unit of the Wisconsin Division of Policy and Budget which is responsible for conducting department-wide program evaluation studies.

Bureau of Quality Compliance (BQC). The sub-unit of the Wisconsin Division of Health which is responsible for regulating institutional health care providers. The bulk of its work is nursing home inspection for licensure and certification.

Certification. The outcome of a process where a nursing home is reviewed by the state (as agents of HHS) for compliance with federal regulations and laws and is approved (certified) to receive vendor payments from Medicare or Medicaid. A facility can be licensed but not certified; however licensure is a prerequisite for certification.

Chapter 50. The chapter of the Wisconsin Statutes governing licensing of nursing homes.

Class A, B & C Violations. Violations of state codes are classed by their severity:

Class A - "...a substantial probability that death or serious mental or physical harm to the resident will result therefrom." (Forfeiture of \$1,000-\$5,000/day)

Class B - "...directly threatening to the health, safety or welfare of a resident." (Forfeiture of \$100-\$1,000/day)

Class C - "...does not directly threaten the health, safety or welfare of a resident. (Forfeiture of \$10-\$100/day)

Conditions of Participation. Eighteen areas of service, personnel and structural requirements that a facility must meet at least to a minimum level prescribed by federal regulations in order to be certified for federal funds under the Medicaid and/or Medicare Programs. The facility compliance with the eighteen conditions of participation is determined by "standards" and "elements" which are requirements that comprise the conditions of participation.

Core Criteria. Compliance and performance "red flags" developed by QAP which suggest surveyors should do a full review rather than sample or screen.

Deficiency. A term used to mean non-compliance with a federal requirement within the conditions of participation. A home cited for deficiencies must correct those deficiencies or risk losing certification in Medicare and Medicaid.

Department of Health and Social Services (DHSS). The Wisconsin agency responsible for the health and welfare of the state's citizens. It is the parent agency of the Bureau of Quality Compliance and agent of HHS for Medicare and Medicaid.

Expansion Districts. QAP expanded into the Madison and Green Bay districts in April 1980.

Facility Assessment. A general term used in this report to refer to review of a home's compliance with state and federal regulations governing the home's physical plant, staffing, and care delivery systems. Two alternative methods of facility assessment are discussed in this report - (a) the mandated full facility survey; and (b) QAP facility screening.

ICF (intermediate care facility). A nursing home that provides intermittent nursing care to patients who do not require SNF care but who require basic health related care and services.

Inspection of Care (IOC). An annual review of each Medicaid nursing home resident by a nurse and social worker, and physician as needed, to assess the quality and appropriateness of care provided to that resident.

Licensure. The outcome of a process whereby a nursing home is reviewed by the state for compliance with state laws and approved (licensed) to operate as a nursing home in Wisconsin.

Medicaid. (also Medical Assistance, Title XIX). The state and federally-funded program which pays for medical care of the poor.

Medicaid Management Study Team (MMST). A one-year task force which began in 1976 to study the Wisconsin Medicaid Program. QAP is an outgrowth of MMST proposals.

Medicare. (also Title XVIII). Federally-funded health insurance program for those over 65 and disabled.

Milwaukee District. QAP began in a subset of homes in this urban district in March 1979 and ended in February 1982.

Nursing Home Quality Assurance Project (QAP). A sub-unit of the Bureau of Quality Compliance carrying out the demonstration of screening and sampling for quality of nursing home care.

Region V. One of the ten HHS regional areas. The Region V office is located in Chicago and serves Wisconsin, Minnesota, Michigan, Illinois, Indiana and Ohio.

Resident Assessment. A general term used in this report to refer to the review of the quality and appropriateness of care received by individual residents in a facility. Two alternative methods of resident assessment are discussed in this report - (a) the mandated inspection of care of all Medicaid residents; and (b) QAP in-depth resident sampling.

Sampling. QAP method of resident assessment in which a random sample of residents of all pay types is reviewed in-depth to determine whether the home's resident care system is working. If the sample fails, surveyors switch to the inspection of care of all Medicaid residents.

Screening. QAP method of facility assessment in which a home is screened using 10 key quality of care criteria. If problems are detected, surveyors may switch to a partial survey or to the full survey and its checklist of 1500 regulations.

Section 1115 Waiver-Only Demonstration. Derives from Section 1115 of the Social Security Act which enables the Secretary of HHS to waive compliance with certain regulations in order to carry out demonstrations. Annual applications are submitted for review and must include experimental design controls and human subject safeguards.

SNF(skilled nursing facility). A nursing home that provides 24-hour nursing care to patients that require it.

Strategy Session. The session conducted prior to entering a QAP method home where the portfolio of the home's past performance is reviewed by the team and details of the visit are planned. For example, if a QAP-eligible home is on surveillance, a decision whether or not to screen must be made.

Survey. The on-site review and report required by state and federal law which will be the basis for issuing a license or certification.

Title XIX and Title XVIII. See Medicaid and Medicare.

Treatment Cells. QAP has included four experimental treatment cells:

<u>Treatment Cell</u>	<u>Facility Assessment</u>	<u>Resident Assessment</u>
New/New (N/N) =	QAP screening	QAP sampling
New/Old (N/O) =	QAP screening	Inspection of care
Old/New (O/N) =	Full survey	QAP sampling
Old/Old (O/O) =	Full survey	Inspection of care

Violation. A term used to mean failure to comply with state codes (Chapter 50 of Wisconsin Statutes and the administrative codes promulgated thereunder) in which case a "Notice of Violation" (NOV) is served on the nursing home. Violations are classified by their severity (see Class A, B and C violations) and may result in forfeitures and other enforcement actions.

WHCRI (Wisconsin Health Care and Research, Inc.). The independent HSS grantee evaluating the Quality Assurance Project. Dr. David Gustafson is the Principal Investigator.

Years 1-3. The first three years of QAP included July 1978 through June 1981 during which the methods remained relatively stable and were tested and refined as originally proposed.

Year 4. The fourth and last year included July 1981 through June 1982. During this year, project methods were modified based on the past three years experience, and the changes in sample size and citing policy for state codes were implemented in October 1981. A three-month extension of the fourth year was approved July 1 through September 29, 1982 to enable completion of final reports and transfer of data for future comparative evaluation with other long-term care demonstrations.

STRATEGY SESSION GUIDELINES

Surveyors should meet in strategy sessions prior to the monthly scheduling meeting. The following should be covered at the strategy session. This list is a touch off point for discussion and is not meant to limit the scope or direction of the session in any way.

1. What is the past history of the facility?
2. What is the LOC history?
3. Should an old survey method be used rather than a new?
4. Who should the RAC be? (if o/n)
5. Should special advisors accompany the survey team? If so, who will contact them?
6. For what day should the advisory NHA be scheduled?
7. What time should the MD arrive?
8. When should the team arrive at the facility?
9. What do team members want to do first at the facility?
10. When should the team meet to critique the summary conference tape and establish the direction of follow-up?

It's the responsibility of the FAC to see that information on facilities to be scheduled is available for surveyors' review at the strategy session and to lead the session discussion.

Guidelines for Surprise Surveys

Surveyors should consider surprise surveys at each scheduling/strategy meeting.

A. Choosing a Facility

Any one of several things might make surveyors consider a surprise survey:

1. ...if complaints have been received about a home since the last survey.
2. ...if the district has received either a very low or very high number of physician plans of care (PPOC's) for reevaluation of care levels.
3. ...if, during the previous resident assessment, the results of the sampling for level of care has changed a home with a "good" LOC history to an "average" history.
4. ...if, during the previous resident assessment, the sampling for level of care has placed a home with an "average, bordering on problem" LOC history in the passing area.
5. ...if surveyors have completed sampling, Inspection of Care, inservice, and/or consultation on setting care levels and now want to see if the home has made improvements.
6. ...if previous survey results indicate to surveyors that it might be worthwhile.

B. At the Scheduling Meeting

Surveyors should schedule any surprise surveys at the monthly scheduling meeting. They should also complete a Monthly Scheduling Document, listing survey date, surveyor names, and the purpose of the survey. (If surveyors schedule a surprise survey at times other than the monthly scheduling meeting, they should complete a Monthly Scheduling Document as usual and send one copy to the Central Office Scheduling Coordinator.)

1. A surprise survey may be scheduled for any facility in the N/N cell.
2. Surveyors should determine the purpose, team composition and duration of the surprise survey.
3. Surveyors may choose to survey only one care area, several areas, or the entire facility.
4. Surveyors may schedule any number of team members for the survey. They may also schedule a special advisor.

C. At the Survey

1. Surveyors should always use the Summary of Findings form to report results of the survey. They may also use the FA and RA worksheets in total or in part, depending on which areas are screened, but these are not required.
2. Surveyors should document the status of all areas listed on the Monthly Scheduling Document.
3. Surveyors should document any areas surveyed which require follow-up, such as NOV's, consultation, further investigation, etc.
4. Surveyors should record on the Summary of Findings form that this is a surprise survey.

CORE CRITERIA THAT MAY MANDATE A FULL SURVEY OR FULL IOC

NOTE: The decision on whether to switch to a full survey and/or IoC depends on the nature of the home's problems. If one or more of these criteria are present, strong consideration should be given to scheduling a SSI and/or IoC. Rationale to use the screening and/or sampling process in these homes must be documented in the comment section of the Monthly Scheduling Document.

- A. Home is under surveillance.
Key questions to review in deciding:
 - a. reason for surveillance
 - b. duration of surveillance
 - c. outcome/status of surveillance
- B. Home received a total of 2 or more Class A or B violations since the last survey.
Key questions to review in deciding:
 - a. were the NOVs an isolated incident or indicative of a system problem
 - b. what is the outcome/status of the problem area
- C. Home is on the Enforcement Supervision meeting agenda.
Key questions to review in deciding:
 - a. why is the home on the agenda
 - b. what is the current status
- D. Home has undergone a change in ownership.
Key questions to review in deciding:
 - a. was the change of ownership accompanied by a change in key staff
 - b. was the change in ownership accompanied by a change in support staff
 - c. what were the results of the last annual survey/follow-up visits
- E. Home will receive its first annual survey.
Key questions to review in deciding:
 - a. what were the results of the initial licensure/certification survey
- F. Complaints have been received and substantiated since the last annual survey.
Key questions to review in deciding:
 - a. what was the nature of the complaint
 - b. what is the status/outcome of the complaint

BUREAU OF QUALITY COMPLIANCE

Quality Assurance Project
Introduction to New Survey Process

Your home, through random selection, is eligible to participate in the testing of an alternative survey method which has been piloted in the State of Wisconsin since July 1978. The Bureau of Quality Compliance, Division of Health, is attempting to demonstrate that it is possible to determine whether a home is providing good care and accurately setting care levels by screening the home in 10 key areas and examining the care of a sample of residents. The new survey methods were developed to be used in homes with a history of providing good care. The administration of this demonstration is through the Quality Assurance Project, a unit within the Bureau of Quality Compliance, and regular Bureau survey staff carry out the new survey methods.

The survey team does, however, include a new member, an advisory nursing home administrator from a facility outside your immediate area. The advisory administrator's role on the survey team is to gain an overall impression of your home's care system, atmosphere, philosophy, and management and to advise the survey team.

Although your home is eligible to receive both portions of the new survey methods, surveyors may choose to complete either the Inspection of Care or Single Survey Instrument in place of the new methods. If this is done, the team coordinator will tell you this during the introductions.

The survey process begins with the resident assessment which is followed by the facility assessment. The resident assessment team includes a social worker, nurse and possibly a physician. In larger homes an additional social worker and nurse may complete a portion of the resident reviews.

When the resident assessment team enters your facility, after initial introductions, they will want to take a short tour. After the tour, using a computer generated list of random numbers and an up-to-date census list, the team will select a random sample of residents of all pay types (Medicaid, Medicare and private pay) for an in-depth review. Because the resident sample may include private pay residents, the team may ask your staff for help in determining which private pay records are eligible for review.

Once the resident assessment is completed (usually after three days), the nurse and social worker will be joined by the sanitarian, engineer, and the advisory NHA to begin the facility assessment. The additional team members will want to make a brief tour of your facility. The facility assessment consists of reviewing ten key areas and will include interviews with members of your staff including nursing aides, housekeeping staff and kitchen staff. The team will want to observe at least one meal being served. They may also request policy books, some personnel records, additional resident charts and other information which may aid their assessment. The engineer will want to continue with an extended tour of your facility, with either you or a staff member familiar with maintenance, new construction, etc. Team members will meet with one another throughout the survey.

One person, the sanitarian, acts as coordinator for the survey team and will schedule an exit conference with you and your staff and surveyors at the end of the survey. At the exit conference the team will present a general statement of their findings. This will include both problem areas and areas in which you are doing a very good job. There are a variety of state actions surveyors can choose for each problem area, depending on the severity of the problem found. The surveyors can choose to:

- cite a violation.
- investigate further; the surveyor may feel s/he does not have enough information to make a judgment based on the screening and opt to come back to your home at a future date.
- counsel in a certain area; the surveyor has identified that your home has a problem which the surveyor can help to correct by providing information at the time of the survey.
- refer a consultant to your home.
- use a portion of or the full SSI (old survey method) after the initial screening.
- ask that you submit PPOC's for certain residents.
- select a second resident sample to interview additional residents and review their charts.
- do IoC evaluations for all Title 19 residents after initial screening.
- do nothing further at this time.

The team will present a summary of their findings to you, discussing the problems found and the state actions. The surveyors will ask you to write out actions your home will take to correct the problems found.

If your facility is 125 beds or less, the survey process will take approximately five days. The team will tell you on day one when they expect to exit. Larger homes may require additional time. Hopefully, the new survey methods will mean less disruption for your staff and residents and will allow the surveyors to focus their time on resolving problems rather than on the survey process itself.

If you have further questions about the new survey methods, please contact the Quality Assurance Project office in Madison at (608)266-6633.

to/2571

LEVEL OF CARE
PERFORMANCE EVALUATION

ATTACHMENT 6

Dist: White-D.O.
White-FACILITY
Pink-C.O.
Yellow-H.C.F.A.

FACILITY _____ DATE _____

CITY _____ LOC HISTORY _____

STEP 1: CHECK ☒ THE NUMBER OF RESIDENTS REVIEWEDCHECK ☒ THE NUMBER WITH INAPPROPRIATE LEVELS OF CARE

Number of residents reviewed	Acceptable	Decision Criteria (Apply Step 2)	Medical Review Required
Out of 10-11 ☐ residents reviewed,	Zero? ☐	1-2? ☐	3 or more? ☐
Out of 12-14 ☐ residents reviewed,	Zero? ☐	1-3? ☐	4 or more? ☐
Out of 15-18 ☐ residents reviewed,	1 or less? ☐	2-3? ☐	4 or more? ☐
Out of 19-20 ☐ residents reviewed,	1 or less? ☐	2-4? ☐	5 or more? ☐
Out of 21-25 ☐ residents reviewed,	2 or less? ☐	3-4? ☐	5 or more? ☐
Out of 26 ☐ residents reviewed,	2 or less? ☐	3-5? ☐	6 or more? ☐
Out of 27-32 ☐ residents reviewed,	3 or less? ☐	4-5? ☐	6 or more? ☐
Out of 33-38 ☐ residents reviewed,	4 or less? ☐	5-6? ☐	7 or more? ☐
Out of 39 ☐ residents reviewed,	5 or less? ☐	6? ☐	7 or more? ☐
Out of 40-44 ☐ residents reviewed,	5 or less? ☐	6-7? ☐	8 or more? ☐
Out of 45-46 ☐ residents reviewed,	6 or less? ☐	7? ☐	8 or more? ☐
Out of 47-50 ☐ residents reviewed,	6 or less? ☐	7-8? ☐	9 or more? ☐

STEP 2: Check ☒ and complete this section if required by Step 1.

LOC HISTORY		Required Action	Date of Action/Comments
DECISION CRITERIA	Good ☐	No Further Action Necessary	
	Borderline ☐	Second Sample Required	
	Problem ☐	Full Medical Review Required	

STEP 3: List PPOC's to be submitted.

NAME	MA OR SSI #	DATE RECEIVED

STEP 4: Document the findings from the sample and any further action (i.e., second sample, medical review) on the Summary of Findings form.

RAC _____ DATE _____

Date: November 2, 1979

File Ref:

To: LOC/Sampling File

ATTACHMENT 7

From: Mike/Sandy

Subject: Procedure for Updating Level of Care Histories

A nursing home's ability to assign levels of care accurately may change over time. The ratings developed to reflect the homes' histories must take this into account. A procedure for computing and updating level of care histories annually is described here.

The home is classified by looking at the last two "years" of data on care levels. The worse rating becomes the home's new rating. Thus, it takes two "good" years to be rated "good", a rating of "good" and "borderline" will be called "borderline." One exception to taking the lower of the two ratings is the case of "good" and "problem" years for which we will assign "borderline" as the new rating. This approach provides a stronger incentive for homes with a history of problems in setting level of care to improve their resident review systems.

Sampling Assessment. If a home did not receive a full resident assessment this year, look at the wrong levels of care found during the initial sample. If the home passed, its history for the year is "good". If the home was in the decision area and eventually passed, it should be considered "borderline". (If the home failed and a full review was done, follow the rating procedure for full medical review.) Look at the home's present LOC rating (in Monitoring Diary), consider it to be last year's rating and determine the updated rating using the guidelines outlined above. (Also see addendum.)

Full Medical/Professional Review. When a home received a full review (whether as a result of flunking the sample or electing to "do it the old way" based on a history of patient or level of care problems) look at the percent of wrong levels of care from the full review and apply the cutoffs we have used in the past:

less than 14% wrong LOC = good

between 14-30% wrong LOC = borderline

more than 30% wrong LOC = problem.

When the full review is done, the findings of the sample are disregarded. As a separate study, homes which are sampled and later have a full review will be studied to compare the methods. If there are inconsistencies, we will look further at the sampling procedure to see if there are problems with selecting the sample, size of the sample, etc.

Control Homes. Histories for control homes will be determined as above for full reviews. We will then make comparisons between the histories of new method and control homes to monitor the effectiveness of the sampling procedure

Example 1. 1976 level of care error rate was 20%, 1977 LOC error rate was 8%, 1978 sample landed in the decision area (one LOC wrong out of 10). A full review was not done. The current level of care rating would be obtained as follows: 1977 rating was "good," 1978 rating was "borderline"; the updated rating is thus "borderline."

Example 2. (control and full review homes) 1976 level of care error rate was 30%, 1977 LOC error rate was 7%, 1978 full review LOC rate was 35%. The current LOC rating is "borderline" since 1977 was "good," and 1978 was "problem."

ADDENDUM

LOC Procedure that we used for rating homes that were sampled in 1978:

1. For 1978 rating - use the new method (sampling assessment) rating procedure for sample - as described above.
2. Look in the LOC list in the Project Monitoring Diary for the rating based on 1975 through 1977 data. ('75 - '77).
3. Use the '78 rating (from 1 above) and the '75 - '77 rating (from 2 above) to get the '78 "updated/combined" rating. Take the lower of the two for the combined rating--unless they are "problem" and "good"--in which case the combined rating should be "borderline.". This will be the updated/combined rating for 1978. This updated rating was then combined with the '79 rating to provide the homes' current LOC rating.

NOTE: The impact of always picking the worse of the two ratings is that a home that has one "problem" or "borderline" year can never have a current LOC rating better than "borderline." This will always give QAP the benefit of caution (helps ensure bad homes aren't passing). The ratings and updating procedure should be reviewed in a year or two to see if any homes are being held back because of one "off" year.

Date: July 9, 1981

File Ref:

ATTACHMENT 8

To: File

From: Joy Stewart
Quality Assurance Project

Subject: Revising the 10% Sample for Resident Assessment - History and Rationale.

Since we are moving away from the present 10% sampling plan, it seems appropriate to outline for the record where we have been and the justification for the planned changes. To facilitate future developmental work, methodological weaknesses and omissions in the new sampling plan are also highlighted. Data on sampling error and sample sizes included in this report have been obtained with the assistance of Dave Balsiger and Brian Joiner of the UW Stat Lab.

This paper is divided into five primary sections - (A) a brief review of current sampling procedures and method of computing level of care performance histories, (B) weaknesses in the present methods, (C) proposed revisions and their justification, (D) other options, and (E) limitations of the revised sampling plan.

A. Overview of the Present 10% Sampling Plan

The level of care performance history is used to categorize a home's past performance at accurately setting levels of care for its residents. QAP computes an initial level of care history for each home at the outset and then the history is updated annually based on the home's most recent survey. To compute the initial history, the percent of incorrect care levels found on the two most recent surveys are calculated. For each of the two years, homes are grouped into one of three categories: (1) A good home is defined as one having 0-13% of its residents at incorrect care levels as assessed by state surveyors. (2) A borderline home is defined as one having 14-30% of its residents misclassified. (3) A problem home is one having more than 30% of its residents misclassified. The worst of the two years is designated the "level of care history". Once the initial level of care history is established, it is updated each year by comparing the home's current history with the most recent review using the above definitions, and the worst of the two ratings is chosen. (See Monitoring Diary "Level of Care" for exceptions to the rule.)

Current guidelines suggest that surveyors review a home's history during the strategy/scheduling meeting in order to decide whether to sample or do a full review on the upcoming annual survey. If sampling is selected, QAP surveyors draw a random sample of residents - 10% of the home's total population of residents or a minimum of 10 residents. Based on the number of incorrect care levels found in the sample of residents, homes fall into one of three categories - (1) acceptable (pass the sample), (2) decision criteria, or (3) full review required (fail the sample). Surveyors use the "Level of Care Performance Evaluation" form to determine which category a home is in based on the sample size and number of errors found.

If a home falls into the decision criteria, surveyors check the home's level of care history. If the history is good, the home passes the sample. If the history is borderline, a second sample of residents is drawn. If the home has a problem history, the homes fails and a full review is required.

B. Accuracy of the 10% Sampling Plan

1. Weaknesses in Current Level of Care History Procedures

Under current guidelines, homes fall into one of three categories based on the total number of residents found to have incorrect care levels - good (0-13%), borderline (14-30%), and problem (31% or more). However, how representative of statewide performance are these definitions? Data provided by the WHCRI evaluation team and data gathered by QAP staff indicate that these definitions do not adequately reflect current nursing home ability to set accurate care levels. WHCRI tabulated results for 189 homes which received a full resident review during 1979. QAP staff tabulated results for all homes (211) which received a full resident review in 1980. Results are shown in the following table.

Table 1

Frequency Distribution of
 Incorrect Care Levels for
 Full IOC Homes*

Percent of Residents Misclassified	Percent of Homes	
	1979	1980
0-4	14	12
5-9	20	17
10-14	28	27
	62%	
15-19	12	16
20-24	15	12
25-29	8	10
	35%	
30-34	3	3
35+	.01	3
	3%	
Average	13.6%	15.4%

*NOTE: Although the data exclude homes which received the 10% sample, one would expect little difference between QAP and non-QAP homes due to QAP's balanced home selection process.

Although the above intervals for percent of residents misclassified are not identical to the QAP definitions of good, borderline and problem homes, they do enable us to estimate the percent of homes in the three QAP categories in 1979 and 1980. For example, in 1980 approximately 56% of homes are "good", 38% are "borderline", and 6% are "problem". As a result, we can draw one of two conclusions - (1) our definitions are too lenient; or (2) most of the state is already at acceptable performance levels.

Our experiences with the present procedures for computing LOC histories have also illustrated a second problem. Homes are overly penalized for past performance problems, and once a home is ranked "borderline", it cannot move out of this category. As a result, a steadily increasing percentage of project homes are being classified as "borderline", and the level of care history is not discriminating between real differences in homes.

2. Sampling Error of the 10% Sample

Given these working definitions of home performance (setting aside for a moment the question of their adequacy), what are the probabilities that surveyors are making the correct decision to pass or fail a home based on our sampling cut-offs? The UW Stat Lab has provided us with computer-generated tables which show the probabilities of accepting and rejecting homes using the 10% sample in 30, 50, 100 and 150 bed homes. The following table illustrates the percentage of correct and incorrect judgments made by surveyors using the current sampling cut-offs and definitions of good and problem homes.

Table 2

QAP Year One-Three
 Sampling Error for
 Full IOC Cut-Offs

Size of Home	Sample Size	Full Resident Review Required - # Incorrect	Probability of Rejecting a Home	
			Good* Homes	Problem** Homes
30	10	3 or more	10%	66%
50	10	3 or more	13%	64%
100	10	3 or more	14%	63%
150	15	3 or more	14%	73%

* Good = 1-13% misclassified

** Problem = 31% or more misclassified

As this table shows, in a 30-bed home, QAP correctly identifies 66% of the problem homes and, conversely, incorrectly accepts 34% of such homes; QAP conducts unnecessary full reviews in 10% of the good homes and appropriately samples in 90% of these homes. In 50 and 100-bed homes, we correctly reject 64% and 63% of the problem homes, respectively, but risk overlooking 36-37% of these homes. In 50 and 100 bed homes, QAP conducts unnecessary full reviews in 13%-14% of the good homes and appropriately samples in 87%-86% of the good homes, respectively. In a 150-bed home, we correctly identify 73% of the problem homes and risk overlooking 27% of such homes; we risk conducting an unnecessary full IOC's in 10-14% of the good homes. Although the decision to reject a good home is not as serious an error as incorrectly accepting a bad home, it does create unnecessary work for the surveyors. Clearly, these probabilities of making an incorrect decision can be improved.

C. Revised Sampling Procedures and Sample Sizes

1. Revised Sampling and Level of Care History Procedures

The first of three primary changes being made in the sampling procedures is elimination of the second sample option when a home falls in the decision area. We are substituting a single sample pass/fail system. This change was made at the recommendation of our consultant Brian Joiner. He felt that the double sample combined with the use of the home's history was too cumbersome.

However, we did not want to discontinue use of the level of care performance history. Our subjective feeling (partially borne out by monitoring data) is that the home's level of care history is a useful predictor of future performance. In the past, we had used this history to decide whether to pass/fail the first sample or to draw a second sample. Since we were discontinuing use of a double sampling plan, we also had to modify our use of the home's level of care history.

We want to change use of the history to a front-end check and field test what is called "tightened inspection". Essentially, the worse the home's history, the tighter the inspection becomes. Based on a home's history, a surveyor may take one of three actions: (1) In homes with a good or average history, the revised sample sizes and error cut-offs described in Table 4 (see Section C, 2 "Selecting New Sample Sizes") are applied. (2) If a home's history is in the lower end of the average category bordering on a problem rating, surveyors are encouraged to increase the sample size by five residents. (3) If a home has a problem history, no sample is taken and a full inspection of care is required.

The third and last major change has been in method of computing level of care histories. At the suggestion of our consultant Brian Joiner, we are adopting a three-year weighted history which can be updated each year using results from the preceeding three years. It is weighted for whether the inspection was a sample or full review. The most recent years are weighted higher than earlier years. Lastly, sample outcomes are weighted with an "error factor" (see following paragraph). The resulting formula is as follows:

$$\frac{(1 \times N_1 \times P_1) + (2 \times N_2 \times P_2) + (3 \times N_3 \times P_3)}{(1 \times N_1) + (2 \times N_2) + (3 \times N_3)}$$

where N = number of residents reviewed

P = percentage of incorrect care levels
identified in the review

1 = earliest of three previous years

2 = middle year

3 = most recent year

As an interim measure, a standard "error factor" of 6.6% is being added to the observed percentage of incorrect care levels in all homes which received and passed the 10% sample. This error factor is being added to compensate for the apparent tendency of surveyors to pass the 10% sample prematurely as seems to be indicated by our second year monitoring data. The 6.6% is derived from data reported for our second project year (see Second Annual Report, 1979-1980) and is equal to the difference in percent of incorrect care levels found in new method and old method homes - 8.8% in homes eligible for resident sampling and 15.4% in homes assigned to the full review treatment cell. Although this error factor is only a crude estimate of the difference between the observed error rate in the samples vs. the actual error in these homes, it does permit us to continue to use level of care histories with a little more confidence until the problem of possible surveyor bias can be investigated by our federal evaluators and hopefully resolved through increased surveyor training.

Based on the weighted level of care history score, homes are categorized as good, average or problem using the same definitions we employed in selecting the new sample sizes (see Section C, 2 "Selecting New Sample Sizes").

2. Selecting New Sample Sizes

In order to select new sample sizes, there were two sets of statistical values that had to be established: (a) definition of "good", "borderline", and "problem" homes, and (b) acceptable probabilities for correctly identifying good and problem homes (and conversely, tolerable probabilities for making an incorrect decision). These choices are arbitrary ones and are not easy to make.

The current definitions of good and borderline homes seemed too lenient. Using our 1980 IOC data (see Table 1), we developed the following new definitions:

Good homes = 0-9% misclassified (29% of state homes)
Average homes = 10-24% misclassified (55% of state homes)
Problem homes = 25% or more misclassified (16% of state homes)

Using 1980 statewide norms, we have three general categories of homes, and "average" constitutes the largest single group (55%). The next largest group is the good homes (29%), and the smallest group is the problem homes (16%). Although still arbitrary, these definitions are based on the 1980 distribution of homes' performance at accurately setting care levels. As this performance changes over time, the definitions can be updated as needed.

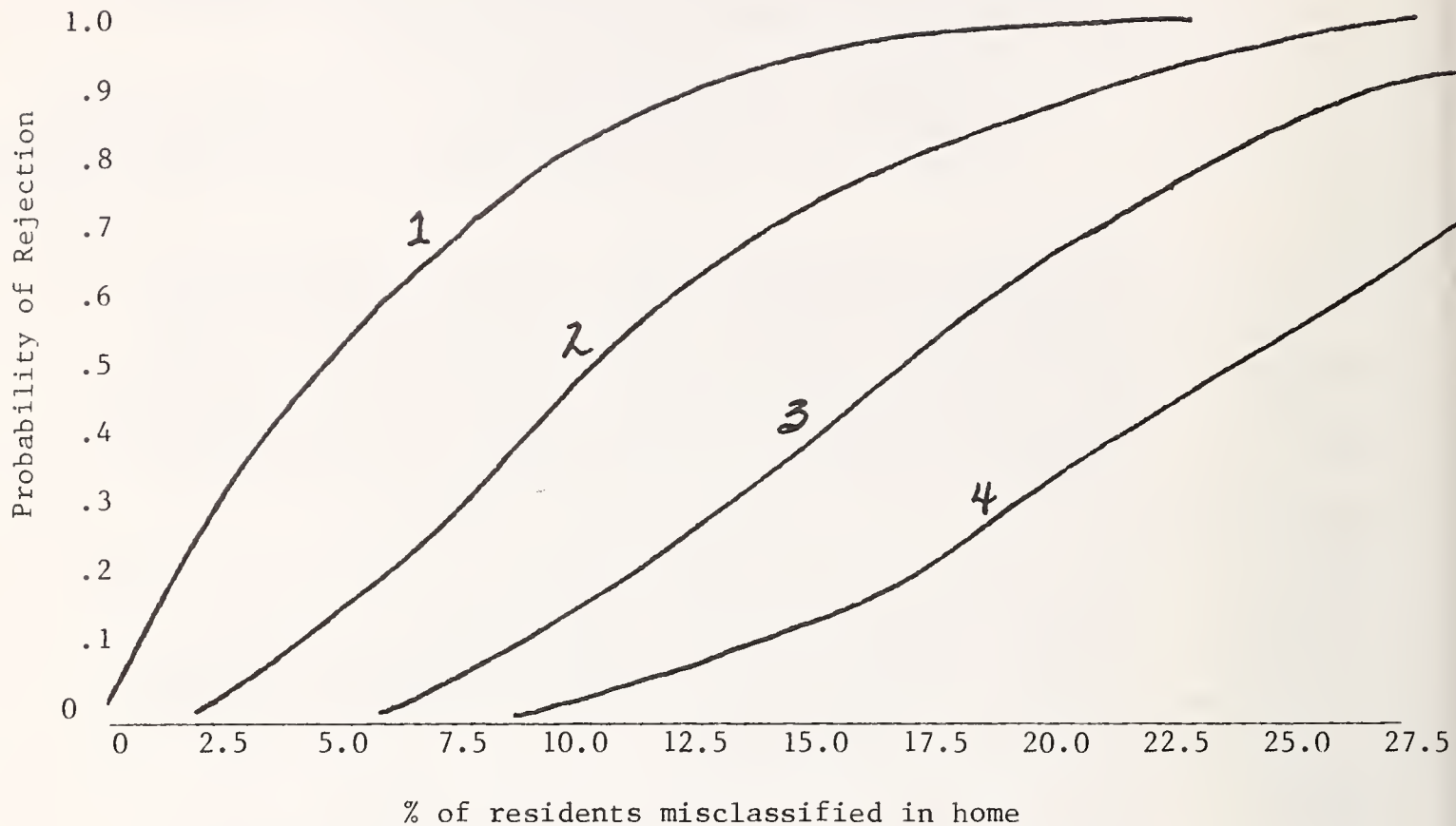
The acceptance levels and probabilities of rejection were more difficult to establish. We faced the task of finding the most functional sample sizes and pass/fail cut-offs which would keep incorrect rejections (of good homes) to a minimum while keeping correct rejections (of poor homes) to a maximum.

The University of Wisconsin Stat Lab provided us with computer-generated operating characteristic curves for different sample sizes in homes of varying size. The discriminatory power of a sampling plan is shown by its operating characteristic (OC) curve. The abscissa for this curve is, in our case, the percent of residents misclassified in the home that is being sampled. The ordinate of the curve is the probability that the home will be rejected (i.e., fail the sample). A different curve can be computed for different rejection levels, i.e., the minimum number of errors which will cause the sample to fail. A sample set of OC curves is shown in the following table:

Table 3

Home Size = 50
Sample Size = 15

Error Cut-Offs = 1,2,3,4



This table illustrates the practical considerations in selecting the error cut-offs for a particular sample size. The probability of rejecting any single home, whether good or problem, increases as the number of acceptable errors allowed in the sample decreases. Thus, if we aim for a 100% success rate on problem homes, we automatically pay the price of a high error rate on good homes. If we aim for a 100% success rate on good homes, we automatically pay the price of a high error rate on problem homes.

Our choice was complicated by the fact that we are only interested in a narrow range of the total distribution of homes. Given our definitions of homes, we want to essentially discriminate between homes that have between 9% and 25% of their residents misclassified out of a range of 0 to 100%. The narrower the difference between good and problem homes, the less likely we are to discriminate successfully between the two groups of homes.

The above OC curve illustrates the choices to be made. If we take a sample of 15 residents in a 50-bed home, we have the following choices:

- a. Allow 2 errors in a sample of 15 implies:
 1. rejecting ("failing") 48% of the good homes.
 2. rejecting 95% of the problem homes.
- b. Allow 3 errors in a sample of 15 implies:
 1. rejecting 15% of the good homes.
 2. rejecting 78% of the problem homes.
- c. Allow 4 errors in a sample 15 implies:
 1. rejecting 2% of the good homes.
 2. rejecting 52% of the problem homes.

Clearly, choice B above gives the best rate of success in both good and problem homes. Choice A fails too many good homes, while choice C lets too many problem homes slip through.

Based on our review of the OC curves provided by the Stat Lab, we set as our goals to:

- successfully reject problem homes (defined as 25% or more of their residents misclassified) at least 80-85% of the time.
- incorrectly reject good homes (defined as 0-9% of their residents misclassified) no more than 10% of the time.

By manipulating the sample size and error cut-offs, we were able to meet these goals. Dave Balsiger of the Stat Lab provided us with this suggested plan:

Table 4

Revised Sample Sizes

<u>Home Size</u>	<u>Sample Size</u>	Range of Probability of Rejection		
		<u># Incorrect- Full Review Required</u>	<u>Good Home</u>	<u>Problem Home</u>
0-10	All			
11-20	10	2	0-10%	85-100%
21-40	15	3	0-10%	83-97%
41-125	20	4	0-10%	80-89%
126-349	25	5	5-8%	80-83%
350-700	30	6	6%	80-81%

Thus far this paper has focused on probabilities of rejecting good and problem homes. However, the majority of homes fall into the intermediate range, i.e., 10%-24% of their residents misclassified. The probability that these homes will fail the sample falls generally between 10% and 85%. The larger the percent of residents misclassified, the more likely the home is to fail the sample. For example, in a 100-bed home with a sample size of 20 and a cut-off of four errors, we find the following probabilities:

<u>% of residents misclassified</u>	<u>Probability of rejecting the home</u>
10	11%
12	19%
14	29%
16	40%
18	51%
20	61%
22	70%
24	77%

Using the system of "tightened inspection" as described in Section C, 1 on revised sampling procedures, surveyors are encouraged to increase the sample size by five residents in homes whose level of care history is average, but borders on the problem category, i.e., 20-24% of the residents misclassified. The number of acceptable errors in the increased sample will remain the same. The net effect will be to increase the discriminatory power of the sample, and homes with such borderline histories are even more likely to fail the sample. In the 100-bed home, for example, the probability of failing the sample changes as follows:

<u>Percent of residents misclassified in home</u>	<u>Probability of failing sample</u>	
	<u>Sample size 20</u>	<u>Increased sample size - 25</u>
20	61%	80%
22	70%	84%
24	77%	87%

D. Issues Reviewed/No Further Action Taken

Although the new sampling plan resolves some of the difficulties of the 10% sample, there were a number of issues which we explored but did not follow through on. For future planning and development, these issues are referenced here.

There were other sampling strategies which we only touched upon due to their more complex design. These included a purely sequential plan, stratified samples, and sampling for key diagnoses. The latter two choices were particularly appealing because they guaranteed a more representative sample and critical care residents could be included. Another possibility, one proposed in a paper submitted by a student of Brian Joiner's, was a plan which took into account the degree of error in care level and the reimbursement losses/gains associated with these errors. The paper outlined a formula for computing when the costs of inspection equalled or exceeded the dollars saved through inspection in any single home.

We also considered using a system of "loosened inspection" in homes with a good level of care history. We considered increasing the number of permissible errors in the sample and thus decreasing the likelihood that a good home would fail the sample. However, we decided to postpone this option until there was no longer any need for an "error factor" and we had more confidence in the level of care histories.

E. Limitations to the Revised Sampling Plan

1. Surveyor bias. Evaluation data suggest that surveyors pass the sample prematurely to avoid conducting a full review. This problem remains to be dealt with.
2. Poor LOC history data. In QAP homes where only a 10% sample was drawn, we have questionable data upon which to base a history due to the problem referenced above.
3. This sampling plan is based upon a binary decision - the level of care is either correct or incorrect. The sampling plan was not specifically designed to answer questions about quality of care and we cannot assess how well suited it is for these questions.
4. Data provided by the WHCRI team indicate that interrater reliability for determining care levels is poor.
5. The cut-off points used in the definition of good, average and problem homes as well as the sampling cut-offs are still arbitrary.



LEVEL OF CARE
PERFORMANCE EVALUATION

FACILITY _____ DATE _____

CITY _____ LOC HISTORY _____

CENSUS ON ENTRY DATE _____

STEP 1: Check ☒ the appropriate home
census and sample size drawn.Check ☒ the number with inappropriate
levels of care.

Census	Standard Sample Size	Increased due to History/ Other Problems?	Acceptable	Full Inspection of Care Required
1-10 ☐	All ☐	N. A.	N. A.	N. A.
11-20 ☐	10 ☐	15 ☐	1 or less? ☐	2 or more? ☐
21-40 ☐	15 ☐	20 ☐	2 or less? ☐	3 or more? ☐
41-125 ☐	20 ☐	25 ☐	3 or less? ☐	4 or more? ☐
126-349 ☐	25 ☐	30 ☐	4 or less? ☐	5 or more? ☐
350-700 ☐	30 ☐	35 ☐	5 or less? ☐	6 or more? ☐

STEP 2: List PPOC's to be submitted.

NAME	MA OR SSI #	DATE DUE	DATE RECEIVED

STEP 3: On the Summary of Findings form, document the findings from the sample and any
further action (i.e., quality of care provided, full IOC review).

SAC _____ DATE _____



Dist: White-C.O.
White-FACILITY
Pink-D.O.

LEVEL OF CARE
PERFORMANCE EVALUATION

FACILITY _____ DATE _____

CITY _____ LOC HISTORY _____

CENSUS ON ENTRY DATE _____

STEP 1: Check ☒ the appropriate home census and sample size drawn. Check ☒ the number with inappropriate levels of care.

Census	Standard Sample Size	Increased due to History/ Other Problems?	Acceptable	Full Inspection of Care Required
1-10 ☐	All ☐	N. A.	N. A.	N. A.
11-20 ☐	10 ☐	15 ☐	1 or less? ☐	2 or more? ☐
21-40 ☐	15 ☐	20 ☐	2 or less? ☐	3 or more? ☐
41-125 ☐	20 ☐	25 ☐	3 or less? ☐	4 or more? ☐
126-349 ☐	25 ☐	30 ☐	4 or less? ☐	5 or more? ☐
350-700 ☐	30 ☐	35 ☐	5 or less? ☐	6 or more? ☐

STEP 2: List PPOC's to be submitted.

NAME	MA OR SSI #	DATE DUE	DATE RECEIVED

STEP 3: On the Summary of Findings form, document the findings from the sample and any further action (i.e., quality of care provided, full IOC review).

RAC _____ DATE _____

RESIDENT ASSESSMENT - MD

RESIDENT NAME: Last, First, Middle _____

FACILITY NAME AND CITY: _____

	YES	NO	N.A.	A.Q.	*
1. Chart reflects concerned MD involvement					
2. Complete history and physical exam, diagnoses, current, informative, complete					
3. Most current hospital history and physical exam discharge summary on chart					
4. Progress notes:					
a. Sufficient in number					
b. Evidence of physically examining resident					
c. Evaluate abnormal lab findings					
d. Evaluate abnormal X-Ray findings					
5. Appropriate use of the laboratory, X-Ray					
6. Appropriate use of ancillary therapies (P.T., O.T., Speech, etc.)					
7. Medications:					
a. Documented need					
b. Appropriate					
c. Not duplicative					
8. Appropriate diet					
9. Overall assessment of quality of physician care ()Excellent ()Good ()Area of improvement suggested					

*KEY: NA = Not Applicable; AQ = Answer Qualified

PHYSICIAN COMMENTS: (In addition, explain all "No" or "Answer Qualified" responses.
List number of question.)

MD Signature: _____ Date: _____

An Analysis of the Effect of Wisconsin's
Inspection of Care Reviews on Medicaid
Nursing Home Reimbursement: A Comparison
of the Quality Assurance Project Approach
and the Federally Mandated Approach

by
Bureau of Evaluation
Division of Policy and Budget
Department of Health and Social Services

March 25, 1982

DOCUMENT DIGESTDepartment of Health
and Social Services*Document Title:* An Analysis of the Effect of Wisconsin's
Inspection of Care Reviews on Medicaid
Nursing Home Reimbursement

This Digest summarizes the above document dated: March, 1982

This report summarizes the results of an evaluation of the Medicaid Inspection of Care (IOC) process as it is performed under two methods -- the federally mandated method and the Quality Assurance Project (QAP) method permitted by federal waivers. Both methods are currently in use in Wisconsin. The evaluation provides information related to the costs and savings resulting from conducting IOC reviews and should assist the Department in determining the most efficient and effective approach to resident review.

The IOC process is performed by an IOC team consisting of a registered nurse and a social worker and includes a review of the appropriateness and level (skilled and intermediate) of care of Medicaid nursing home residents. Since the daily Medicaid nursing home reimbursement rate varies by level of care, the decisions of the IOC team on level of care have important financial implications in addition to their effect on the quality of care.

This evaluation analyzed data on 153 homes reviewed under the federally mandated or what is being referred to in this evaluation as the existing method and 167 homes reviewed under the QAP method. This represents almost 12,000 resident reviews under the existing method and 3,300 under the QAP method. The QAP method reviews a sample of the residents in a nursing home rather than all residents as is done under the existing method. Possible outcomes of applying the QAP method are a) the home passes the sample and no further action is taken, b) the home fails the sample and a 100% review is conducted or c) a full 100% review is conducted based on the home's history.

The major findings of this evaluation were:

1. IOC reviews are cost beneficial regardless of whether conducted under the existing method or the QAP method.
2. In terms of net dollar savings to the state, there was little difference between the two methods. However, due to the greater federal match for conducting IOC reviews (75%) than for nursing home reimbursement (56%), statewide application of the QAP method is likely to result in slightly less savings in state funds than under statewide use of the existing method. Various funding proposals being discussed at the federal level may impact on this finding.
3. Nursing homes that "pass" the QAP sampling plan have substantial savings per resident reviewed and thus the residents not reviewed may represent large sums of unrealized savings. Applying the savings realized from residents reviewed in homes that pass the sample to the number of residents not reviewed in 1981 (due to sampling), results in \$350,000 in net program savings (total funds).

Continued

4. Reviewing private pay residents as is done under the QAP method is costly and does not generate Medicaid nursing home reimbursement savings.
5. Large district and yearly fluctuations exist in the percentage of residents misclassified and in reimbursement savings.

Based on this evaluation the following recommendations were made:

- ** The decision to adopt the QAP method or the existing method should be based on grounds other than financial since there was not a large difference between the two methods in their net savings. Further, due to the high volatility in level of care changes from year to year, there is a need to continue to monitor level of care changes and reassess the savings potential of the IOC process. In making this decision, several other findings of this evaluation that are important to be recognized are: a) the QAP method yields a considerably higher dollar savings per dollar of cost than the existing method, b) the surveyor incentives under the QAP method are complex and may have unintended effects, c) the QAP method lowers levels of care to a greater degree than the existing method, and d) the QAP method's ability to screen "bad" homes is questionable.
- ** If the QAP method of resident review is adopted, the review of private pay residents should be questioned.
- ** Further study should be conducted to determine the factors that explain the finding of a high savings per review in nursing homes that pass the sample.
- ** Level of care determination should be made a more consistent and predictable process.

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FOREWORD

This report was prepared by the Bureau of Evaluation, Division of Policy and Budget at the request of the Bureau of Quality Compliance, Division of Health.

Staff of the Quality Assurance Project collected the level of care and reimbursement rate data used in the analysis and Bureau of Quality Compliance staff provided data on program costs.

If there are questions concerning this report, please contact Tim Tyson, Bureau of Evaluation.

INTRODUCTION

In December 1981, the Bureau of Quality Compliance in the Division of Health requested that the Bureau of Evaluation, Division of Policy and Budget review the Inspection of Care (IOC) process in Skilled Nursing Facilities (SNF) and Intermediate Care Facilities (ICF) to determine the costs and savings associated with conducting IOC reviews under the approach being used by the Quality Assurance Project and under the traditional or federally mandated approach.

The purpose of this paper is to report the findings of that evaluation. The paper is organized into four general areas -- Program Description, Methodology, Findings and Summary/Recommendations.

PROGRAM DESCRIPTION

The IOC Process: The appropriateness and level of care for Medicaid nursing home residents are inspected annually by Department of Health and Social Services' staff under what is termed the Medicaid Inspection of Care process. According to federal regulations, the inspection team's review, for residents under age 21 in psychiatric facilities and residents in SNF and ICFs, other than residents 65 and over in institutions for mental diseases, must include 1) "personal contact with and observation of each recipient," and 2) "review of each recipient's medical record."¹ For persons 65 and over in institutions for mental diseases, the review must include a review of each resident's medical

¹ In Wisconsin, the IOC review is performed by a registered nurse and a social worker and is referred to as an IOC team.

record and if so indicated, personal contact and observation of each resident (42 CFR 456.602). The regulations further require that the IOC team determine in its inspection whether the services available in the facility are adequate to 1) "meet the health needs of each recipient and the rehabilitative and social needs for each recipient in an ICF and 2) promote his maximum physical, mental and psychological functioning." Moreover, the team must determine whether 3) "it is necessary and desirable for the recipient to remain in the facility," 4) "it is feasible to meet the recipient's rehabilitative needs through alternative institutional or non-institutional services," and 5) each resident under 21 in a psychiatric facility and each resident in an institution for the mentally retarded are receiving appropriate, active treatment (42 CFR 456.609). The team must inspect the care and services provided to each resident in the facility at least annually (42 CFR 456.609).¹

In Wisconsin, the IOC process, in addition to performing its quality of care function, also determines whether each resident is at the appropriate level of care (SNF or one of the four levels of ICF).² The average daily rate of reimbursement to nursing homes varies by level of care and thus the appropriateness of level of care is important for both patient care and financial reasons.

¹ prior to a recent change in federal terminology, the IOC review was termed Independent Medical Review (IMR) and Independent Professional Review (IPR).

² As of October 1, 1981, the Wisconsin Medicaid program no longer reimbursed for admissions to levels ICF-3 and ICF-4 except for the developmentally disabled (DD) and the chronically mentally ill (CMI). However, Medicaid coverage was continued for persons already at these levels.

The Quality Assurance Project: Since July, 1978, Wisconsin has been granted waivers of certain federal regulations by the federal Health Care Financing Administration in the Department of Health and Human Services to conduct a demonstration of new methods of nursing home inspection.¹ Referred to as the Quality Assurance Project (QAP), nursing home surveyors have the option to intensively review the care of a sample of nursing home residents and to screen the facility for key indicators of quality. The notion is that through sampling and screening, surveyor time can be reallocated from homes providing good care to concentrate on those providing poor care. The QAP originally encompassed the Eau Claire, La Crosse and Wisconsin Rapids districts. It later expanded into the Milwaukee, Madison and Green Bay districts. A federally funded two-year evaluation of the project began in July, 1980.² Both the QAP method and what is being referred to in this analysis as the existing method are being used in Wisconsin.

The IOC process under the QAP approach depends on a home's history, i.e., on the proportion of correctly classified residents in previous surveys and on the home's quality of care. A surveyor upon reviewing a home's history, decides whether to sample or conduct a full (100%) review of the residents in the home. If the sampling avenue is chosen, the surveyor selects a 10% sample of all residents in the home with a minimum sample size of 10 residents.³ The review

¹ The key federal waivers related to the IOC process include: 42 CFR 456.606 (Frequency of inspections), 42 CFR 456.608 (Personal contact with and observation of recipients and review of records), 42 CFR 456.609 (Determinations by team) and 42 CFR 205.120 (Statewideness).

² The federally funded evaluation will not examine the subject of this evaluation -- the costs and savings of resident review.

³ The IOC process in its existing form, reviews only Medicaid nursing home residents. Under the QAP sampling method, all residents are sampled (both public and private pay). The rationale for including private pay is a) quality of care - are Medicaid residents treated differently than private pay, and b) enforcement - are there private pay residents at levels of care for which the nursing home is not licensed.

of the sample is much more intensive than the 100% review. Based on the number of incorrect care levels found in the sample and the home's history, either 1) no further action is taken, 2) a 100% review of Medicaid residents is conducted using the existing method or 3) a second sample of residents is taken.¹

The IOC/Reimbursement Relationship: The QAP is now in its fourth and final year. It will end June 30, 1982. Thus, the situation exists where two nursing home quality assurance methods are in use -- the QAP method and the existing or what is often referred to as the old method. With regard to the relationship of IOC reviews and Medicaid reimbursement to nursing homes, two questions arise: 1) What is the net savings or cost to the state in nursing home reimbursement resulting from IOC level of care changes after taking into consideration the cost of conducting IOCs?, and 2) How does this savings or cost differ between the QAP method and the existing method?²

As the Department must decide whether to adopt the QAP method or features thereof as the favored method of nursing home quality assurance or retain the existing system, these questions are important. With potential reductions in federal funding, added emphasis is given to the need to accurately evaluate the costs and savings associated with IOC reviews.

¹ In October of 1981, the 10% sampling plan was revised to a variable percentage based on the size of the home. In this evaluation, the new sampling plan will be referred to as the "20% sampling plan" since in an average size home of 100 residents, a sample of 20 is drawn. In addition, the option of a second sample was eliminated.

² Again, both methods are being used in Wisconsin. The existing method refers to the federally mandated approach and the QAP method refers to the approach for which federal requirements have been waived.

METHODOLOGY

A cost/benefit type approach was used to ascertain the savings and costs of IOC reviews. The net effect of IOC reviews can be taken as the difference between:

1. the savings or cost to the state in Medicaid nursing home reimbursement dollars resulting from level of care changes, and
2. the Medicaid administrative costs of conducting IOC reviews.

Reimbursement Effect: The reimbursement effect of IOC reviews was calculated by comparing total Medicaid reimbursement to a nursing home before and after the IOC reviews were conducted. The difference between the two being the savings or loss attributable to level of care changes.¹ More specifically, the following formula was used:

Reimbursement Effect =

$$\begin{aligned} & (\text{SNF Residents}_A \times \text{SNF Rate} + \text{ICF-1 \& 2 Residents}_A \times \text{ICF-1 \& 2 Rate} + \\ & \text{ICF-3 Residents}_A \times \text{ICF-3 Rate} + \text{ICF-4 Residents}_A \times \text{ICF-4 Rate}) - \\ & (\text{SNF Residents}_B \times \text{SNF Rate} + \text{ICF-1 \& 2 Residents}_B \times \text{ICF-1 \& 2 Rate} + \\ & \text{ICF-3 Residents}_B \times \text{ICF-3 Rate} + \text{ICF-4 Residents}_B \times \text{ICF-4 Rate}) \end{aligned}$$

¹ This approach is similar to the one used by Brian Joiner, Department of Statistics - University of Wisconsin, in an analysis of the reimbursement effect using a subset of the data set used in this evaluation. The data collection procedure designed by Dr. Joiner is identical to the approach followed here.

where:

SNF Residents_A = the number of residents classified as SNF after the IOC review

SNF Residents_B = the number of residents classified as SNF before the IOC review

SNF Rate = the Medicaid SNF reimbursement rate.

The ICF levels are similary noted.

Data on a sample of 135 Wisconsin nursing homes in 1980 and 185 homes in 1981 were collected by staff of the Bureau of Quality Compliance (BQC) and formed the data set for determining the reimbursement effect. Thus, IOC reviews for the two years (1980 and 1981) were included. The data on level of care changes were taken from BQC Notice to Provider letters and Resident Assessment forms. Reimbursement data were obtained from the Bureau of Health Care Financing, Division of Health.

Administrative Costs: The number of staff hours devoted to conducting IOC reviews during the three month period April through June, 1981, was obtained from the Bureau of Quality Compliance fiscal reporting system. The data were separated by registered nurse and social worker for each of the four districts: Madison, Green Bay, Rhinelander and Fond du Lac.¹ These districts were selected since they would allow a separation of IOC time between the QAP method and the existing method.² The number of reviews conducted was obtained from the Notice to Provider letters and Resident Assessment forms.

¹ In order to control for surveyors crossing district boundaries, the data were aggregated on a facility by facility basis.

² IOC reviews under the QAP method (due to intensive reviewing of the sampled residents) are more time consuming per review than under the existing method.

Applying the average registered nurse and social worker wage rates (including fringes) to the time per review provided an estimate of the salary cost per review. Travel, training and other expenses were gathered from the Bureau of Quality Compliance's fiscal reporting system.

FINDINGS

This section presents the findings of the evaluation. Data are presented for both the existing IOC method and the QAP method. The Findings are divided into four subsections: 1) Descriptive Data, 2) Reimbursement Effect, 3) Administrative Costs and 4) Net Program Savings.

Descriptive Data: This subsection identifies the sample of nursing homes used in the analysis and presents data on the number and percent of residents reviewed and the percent of residents at the wrong level of care (misclassified).

The number of nursing homes, by Division of Health district, included in the study was as follows:

Table 1
Number of Nursing Homes in Study Sample

District	<u>Existing</u>		<u>QAP</u>		<u>Total</u>	
	1980	1981	1980	1981	1980	1981
1 - Madison	13	11	20	41	33	52
2 - Milwaukee	21	24	14	18	35	42
3 - Fond du Lac	23	32	--	--	23	32
4 - Green Bay	7	--	16	38	23	38
5 - LaCrosse	3	3	3	3	6	6
6 - Eau Claire	5	5	5	5	10	10
7 - Wis. Rapids	3	3	2	2	5	5
TOTAL	75	78	60	107	135	185

Thus, for the two year period, 1980 and 1981, the sample consisted of 153 homes reviewed under the existing method and 167 under the QAP method.

Table 2 presents some basic information on the IOCs performed on the sample homes.¹

Table 2
IOC Basic Information

	<u>Existing</u>			<u>QAP</u>			<u>Total</u>		
	1980	1981	80 & 81	1980	1981	80 & 81	1980	1981	80 & 81
Total No. of Residents	5,479	6,319	11,798	4,441	7,883	12,324	9,920	14,202	24,122
No. Reviewed	5,479	6,319	11,798	808	2,453	3,261	6,287	8,772	15,059
% Reviewed	100%	100%	100%	18.2	31.1	26.5	63.3	61.8	62.4
# Misclassified	948	875	1,823	58	260	318	1,006	1,135	2,141
% Misclassified	17.3	13.8	15.5	7.2	10.6	9.8	16.0	12.9	14.2

Over 15,000 Medicaid IOC reviews were conducted in 1980 and 1981 for the sample homes; 78% of which were conducted through the existing method and 22% through the QAP method. This is as expected since for the most part, QAP uses a sampling rather than 100% review. In 1980, QAP reviewed 18.2% of all Medicaid residents and in 1981, 31.1%.²

¹ Throughout this report, unless noted otherwise, residents refers to Medicaid residents only and not private pay residents. As noted earlier, the QAP method reviews some private pay residents as part of the initial sample.

² In October 1981, the QAP method increased its sample size from 10% to 20%. Since one option under the QAP method allows a 100% review, the actual percentage of residents reviewed is larger than the initial sample size. Under the 20% sampling plan (October through December 1981), 43.5% of all residents were reviewed in 27 QAP homes.

In terms of residents at incorrect care levels, the existing method found 15.5% of the residents to be misclassified while the QAP method found 9.8% misclassified. This is consistent with data reported in the evaluation being conducted by Wisconsin Health Care and Research Inc. (WHCRI).¹

Possible outcomes of applying the QAP method are a) pass the sample, b) fail the sample (and a 100% review conducted), or c) revert to the 100% review method. The percent of residents found misclassified by each of these options is presented in Table 3.

Table 3
QAP Options

QAP Method	No. of Homes	% of Total	No. Misclassified	No. Reviewed	% Misclassified
Passed Sample	138	82.6	107	1,570	6.8
Failed Sample	15	9.0	106	840	12.6
Switched to 100%	14	8.4	105	851	12.3
Total	167	100.0	318	3,261	9.8

Nearly 83% of the homes reviewed passed the sample, 9% failed and in 8% of the cases the decision was made prior to sampling, to review all of the residents.

The percent of residents misclassified is substantially higher in the failed and switched groups compared to the group that passed the sample.

It is important to note that there are substantial differences when the data are reported by district (Table 4). In terms of the percent of residents misclassified, both the existing method and the QAP method show large

¹ A September 1980 report by WHCRI indicated level of care error rates of 12.8% for existing method reviews and 7.6% for QAP method reviews.

(three-fold) differences. In terms of the percent of residents reviewed, similar large differences are shown for the QAP method. This results from district differences in the relative frequency with which the three options of applying the QAP method are employed.

Table 4
District Differences by Method

District	<u>Existing</u>		<u>QAP</u>	
	% Reviewed	% Misclassified	% Reviewed	% Misclassified
1 - Madison	100.0	10.7	25.9	12.4
2 - Milwaukee	100.0	20.1	16.5	5.5
3 - Fond du Lac	100.0	13.3	--	--
4 - Green Bay	100.0	6.4	35.5	9.8
5 - LaCrosse	100.0	19.9	10.7	4.0
6 - Eau Claire	100.0	10.3	22.2	8.9
7 - Wis. Rapids	100.0	7.1	70.3	9.6
Total	100.0	15.5	26.5	9.8

Reimbursement Effect: As indicated earlier, the change in nursing home reimbursement results from level of care changes and in this evaluation, the reimbursement effect is based on each home's level of care distribution before and after the IOC team conducts its review weighted by the home's reimbursement rates. Table 5 compares the daily nursing home reimbursement savings for the existing and QAP methods on a per review, per misclassified and per Medicaid resident basis:

Table 5
Reimbursement Savings Per Day by Method

	<u>Existing</u>			<u>QAP</u>		
	1980	1981	80 & 81	1980	1981	80 & 81
\$/Review	\$.146	\$.053	\$.096	\$.248	\$.269	\$.264
\$/Misclassified	.84	.38	.62	3.46	2.54	2.71
\$/Resident	.146	.053	.096	.045	.084	.070

Both methods resulted in lower reimbursement after the IOC reviews were conducted than before. On a per resident reviewed basis, the QAP method lowered reimbursement over twice the amount as that of the existing method (26.4¢ vs. 9.6¢).

When a level of care change is made, it is for a greater dollar amount under the QAP method than the existing method. This can be seen from the \$/misclassified row in Table 5. The QAP method resulted in a \$2.71 net reduction per resident misclassified versus only \$.62 under the existing method. However, when the savings are distributed over all Medicaid residents in the homes, the existing method saves 2.6¢ (\$.096 - \$.070) more per day than the QAP method. Since the existing method reviews all Medicaid residents, the savings per review and per resident are equal. The 2.6¢ is for 1980 and 1981 considered together. There is considerable yearly variation. In 1980, the existing method outsaved the QAP method by 10¢ per day; but in 1981, the QAP method did better by 3¢ per day.

If the QAP savings are further divided into the review options available (pass, fail and switch methods), it can be seen that on a per review basis, all the QAP options save more nursing home reimbursement dollars than the existing method (Table 6 compared to Table 5).

Table 6
Reimbursement Savings Per Day by QAP Option

QAP Option	1980		1981		80 & 81	
	\$/Review	\$/Resident	\$/Review	\$/Resident	\$/Review	\$/Resident
Pass	\$.228	\$.031	\$.250	\$.039	\$.242	\$.036
Fail	.532	.532	.303	.303	.327	.327
Switch	.156	.156	.259	.259	.238	.238

Of course, when the savings are prorated over all Medicaid residents in the home, the savings for the homes that pass the sample are greatly reduced. Keeping in mind, that almost 83% of the nursing homes reviewed under the QAP method pass the random sample (and thus no additional residents are reviewed) and noting from Table 6 that the reimbursement savings per review for homes that pass the sample is not that different from those that fail or switch methods, suggest substantial unrealized reimbursement savings for homes that pass the sample.

In order for a home to pass the sample, it must not have a high proportion of residents at incorrect care levels. Since this is the case (see Table 3) and since the savings per review is high (see Table 6) it follows that the dollar reimbursement change per incorrect care level (misclassified) must also be high for the passed sample group. Table 7 shows this to be true. In fact, the savings per misclassified resident is highest in the homes that pass the sample.

Table 7
Reimbursement Savings Per Day Per Misclassified by QAP Option

QAP Option	\$ / Misclassified		
	1980	1981	80 & 81
Pass	\$3.70	\$3.48	\$3.55
Fail	2.96	2.53	2.60
Switch	3.38	1.85	1.95

An earlier table (Table 5) demonstrated the point that the savings regardless of method varies substantially from year to year. The same can be said for district differences. The variation is substantial (see Table 8).

Table 8
Reimbursement Savings/(Loss) Per Resident Per Day by Method and District

District	1980	Existing		1980	QAP	
		1981	80 & 81		1981	80 & 81
1 - Madison	\$.202	\$.552	\$.385	\$.063	\$.150	\$.125
2 - Milwaukee	.080	(.065)	.002	(.007)	(.013)	(.010)
3 - Fond du Lac	.164	(.035)	.046	--	--	--
4 - Green Bay	(.022)	--	(.022)	.093	.085	.088
5 - LaCrosse	.696	.454	.570	.040	.0	.019
6 - Eau Claire	(.070)	(.112)	(.091)	.0	.109	.056
7 - Wis. Rapids	.489	.213	.349	.023	.130	.078
Total	.146	.053	.096	.045	.084	.070

Administrative Costs: The reimbursement savings just presented must be compared to the cost of conducting IOC reviews to arrive at a net program savings figure. From BQC records for the Madison, Green Bay, Rhinelander and Fond du Lac districts for April through June, 1981, the average amount of surveyor time for IOC reviews is indicated in Table 9.

Table 9
Surveyor Hours by Method

Method	Tot. Hours	All Reviews		No. of Reviews	Medicaid Reviews	
		Tot. Reviews	Hrs/Review		Hrs/Review	Adjusted* Hrs/Review
Existing	1959.5	1,446	1.36	1,446	1.36	1.37
QAP	1402.5**	751**	1.87**	674	2.08	2.04

* Adjusted for inter-district differences in travel time.

**Includes private pay reviews.

IOC reviews performed under the QAP method (which includes homes failing the sample and switching to the existing method) take 38% longer than the existing method (1.87 hours versus 1.36 hours).¹ Since reimbursement savings result from

¹ Of the 751 reviews conducted under the QAP method, 271 were intensive reviews, i.e., the initial sample, and they took an average 2.77 hours per review including travel time.

level of care changes in Medicaid residents only and not private pay residents, surveyor time as well as all administrative costs for that matter must be prorated over Medicaid residents only. This is shown in the next to the last column in Table 9. Since travel time varies by district, the last column is adjusted to neutralize the effect of inter-district differences in travel time. It is these adjusted figures that are used in subsequent calculations.

The hours figures were multiplied by the average administrative cost per hour of surveyor time to arrive at a cost per IOC review. Administrative costs per hour were calculated as follows:

	Annual Salary	Fringe (22%)	Other ¹ Expenses (20%)	Total	÷ 1852 ²
Registered Nurse	\$23,424	\$5,153	\$4,685	\$33,262	\$17.96
Social Worker	22,353	4,918	4,471	31,742	17.14

Total IOC hours were assumed to be divided evenly between social worker and registered nurse to arrive at an overall hourly IOC rate of \$17.55.

Applying the hourly rate to the 1.37 hours per existing method IOC and 2.04 hours per QAP IOC results in a cost per IOC of:

Method	Total Cost Per IOC
Existing	\$24.04
QAP	\$35.80

¹ Other expense include travel, training, supplies and services, telephone, space and district indirect expenses.

² The number of work hours in the year was calculated at 1852 hours. This allows for 10.5 personal holidays and regular holidays and 19 vacation and sick days. The calculation was $2088 - (29.5 \times 8) = 1852$.

Net Program Savings: As of year end 1981, there were 37,752 Medicaid residents in nursing homes in Wisconsin. The results of conducting the IOC process under five different scenarios were estimated. The scenarios are as follows:

Scenario

1. 1980 Experience - This scenario uses the 1980 experience projected statewide. The QAP method followed a 10% sampling plan in 1980.
2. 1981 Experience - This scenario uses the 1981 experience projected statewide. The QAP method utilized a 10% sampling plan through September and a 20% sampling plan from October through December.
3. 1980 and 1981 Experience - This scenario combines the 1980 and 1981 experience.
4. QAP 20% Sample - This scenario is based on the experience of October through December of 1981 (51 homes - 24 existing method, 27 QAP method).
5. QAP 100% - In this scenario, a distinction is made between sampling and the QAP method (intensive resident review). The 1980 and 1981 results of homes that "passed the sample are generalized to the entire state. Further, it is assumed that no private pay residents are reviewed and thus their costs are not reflected in the cost per review. In other words, this scenario applies the intensive QAP review to all Medicaid residents.

Each scenario assumes applying the existing and QAP methods statewide and thus the savings and cost figures represent the entire state for one year. When reference is made to the "1980 Experience" for example, what is meant is that the calculation of the number of residents reviewed and the costs and savings of reviews is based on data for the time period 1980. Other scenarios use the time periods indicated. The key factors used to estimate the statewide impact are:

1. The number of resident reviews to be conducted.
2. The average cost per review. For the QAP method, this depends on whether private pay residents are reviewed and the percentage of residents sampled.

3. The reimbursement per year was calculated by multiplying the savings per day reported earlier by 365.

The results are displayed in Table 10. The difference between total savings and total costs is the net savings or costs in Medicaid reimbursement dollars of conducting IOC reviews. The last column in Table 10 presents the net state savings or costs after applying federal funding ratios of 75% for conducting the IOC reviews and 58% for Medicaid nursing home reimbursement savings.¹

Table 10
Statewide Savings by Method Under Five Scenarios

Scenario	No. of Reviews	Cost/ Review	Total Cost	Savings/ Review	Total Savings	Net Savings	Net Savings
1- 1980 Experience							
Existing Method	37,752	\$24.04	\$ 907,558	\$53.29	\$2,011,804	\$1,104,246	\$ 63,118
QAP Method	6,871	35.80	245,982	90.52	621,963	375,981	13,118
2- 1981 Experience							
Existing Method	37,752	24.04	907,558	19.35	730,501	(177,057)	\$ 8,118
QAP Method	11,741	37.21	436,883	98.19	1,152,849	715,966	31,118
3- 1980&81 Experience							
Existing Method	37,752	24.04	907,558	35.04	1,322,830	415,272	31,118
QAP Method	10,004	36.86	368,747	96.36	963,985	595,238	31,118
4- 20% QAP							
Existing Method	37,752	24.04	907,558	120.45	4,547,228	3,639,670	1,661,118
QAP Method	16,422	39.67	651,461	117.53	1,930,078	1,278,617	61,118
5- 100% QAP (MA only)							
Existing Method	37,752	24.04	907,558	35.04	1,322,830	415,272	31,118
QAP Method	37,752	48.61	1,835,125	88.33	3,334,634	1,499,509	94,118

¹ These funding ratios of 75% and 58% respectively are referred to in this paper as the current funding ratios since they were current until October 1, 1981. A number of actual and potential federal changes taking place may alter these ratios.

As can be seen from Table 10, both methods for all scenarios except the 1981 experience for the existing method show a net savings in reimbursement dollars. In terms of state dollars, a net savings is always indicated.

Scenario one which is based on the 1980 experience places the net savings for the existing method at about \$730,000 more than the QAP method (in total dollars). Scenario two which is based on the 1981 experience reverses the situation putting the QAP method at a \$890,000 advantage. This large fluctuation is due to the large reimbursement savings per review change for the existing method between 1980 and 1981. The reimbursement savings per review under the QAP method remained quite stable. When the 1980 and 1981 experiences are combined (scenario three), the QAP method results in a slightly greater savings (\$180,000) than the existing method. The QAP method through its much higher savings per review accrues over 70% of the savings of the existing method but at 40% of the cost. When the federal funding ratios are taken into consideration in scenario three (75% for conducting IOC reviews and 58% on nursing home reimbursement), the QAP method's advantage disappears and the advantage swings to the existing method by an almost negligible \$16,000.

Scenario four, based on limited data under the new 20% sampling plan, puts the existing method at a substantial (\$2.3 million in total funds and \$1.1 million in state funds) advantage over the QAP method. This is due to an unusually high savings per review figure. Actually, both methods show very high savings per review. As this scenario is based on a very small sample (51 homes) and since savings per review has been shown to be a volatile number, not a lot of confidence can be placed in this scenario.

Scenario five may be the most interesting. It is based on the savings per review figure for the 1980 and 1981 experience of homes that passed the random sample. This consisted of 138 homes and 1,570 reviews. Assuming the savings per review for this group could be realized statewide, the net savings would be substantial (\$1.5 million in total funds, \$.9 million state funds) even though these intensive reviews are twice as costly as existing method reviews. Since the homes that pass the sample do not receive any further review, this scenario suggests substantial unrealized savings due to sampling and raises questions about the ability of the QAP sampling method to target homes with level of care errors of a large magnitude.

Another way to view the reimbursement benefits is in terms of reimbursement savings per dollar of costs. These ratios are presented in Table 11 for total funds and state funds. As can be seen, the QAP method (except for scenario four) uniformly offers a higher ratio of savings to costs.

Table 11
Savings/Cost Ratios by Method Under Five Scenarios, Total and State Funds

Scenario	Existing Method		QAP Method	
	Total Funds	State Funds	Total Funds	State Funds
1 - 1980 Experience	2.22	3.72	2.53	4.25
2 - 1981 Experience	.80	1.35	2.64	4.43
3 - 1980 and 81 Experience	1.46	2.45	2.61	4.39
4 - 20% Sample	5.01	8.42	2.96	4.98
5 - 100% QAP (MA Only)	1.46	2.45	1.82	3.05

At this time, there are numerous federal funding possibilities which would have an impact on the savings and costs calculations presented here. Several possible federal funding options are as follows:

1. Maintain the 75% IOC and 58% nursing home reimbursement ratios that existed up until October 1, 1981. This is being referred to as the "current situation."
2. Eliminate the 75% IOC special matching rate by lowering it to 50% (as contained in federal budget proposals) and lower nursing home reimbursement matching by 3% as is now being implemented by the federal government.
3. Maintain the special matching rate but lower nursing home reimbursement matching by 3%. This may be the situation during federal fiscal year 1982 (current year).
4. This possibility reflects the situation of no federal match which could occur if a cap were placed on federal funding for IOC reviews.
5. Federal takeover of Medicaid. Of course, depending on funding and service provisions by the federal government, state funds may also be involved.

Table 12 presents the five possible situations. These are only examples of the many funding combinations. Under all possibilities listed, except 4 - no federal match using the existing method, IOC reviews are still cost beneficial.

Table 12
Net State Savings/(Loss) by Method Under Four Funding Possibilities
Using the 1980-81 Scenario

Possibility	Federal Percent Match		Net State Savings	
	IOC	Nursing Homes	Existing	QAP
1 - Current Situation	75	58	\$328,669	\$312,687
2 - Eliminate Special Matching	50	56	\$128,266	\$239,780
3 - Federal Fiscal Year 1982	75	56	\$355,156	\$331,967
4 - No Federal Match	0	56	(\$325,513)	\$ 55,406
5 - Federal Takeover	100	100	-	-

SUMMARY/RECOMMENDATIONS

The major findings of this evaluation can be summarized as follows:

1. IOC reviews are cost beneficial regardless of whether conducted under the existing method or the QAP method. It can be concluded with reasonable certainty that the IOC process results in a net dollar savings. Current federal funding proportions further enhance the net savings of the IOC process in terms of state funds since costs are only 25% state dollars while savings are 42% state. There are, however, numerous funding possibilities that have recently been discussed or proposed at the federal level which might impact on this finding.
2. Although the QAP method represents a higher savings return per dollar of costs, there is not a large difference between the two methods in their net dollar savings to the state. In terms of state dollars, the existing method is at an advantage due to the greater federal match for conducting IOC reviews than on nursing home reimbursement. Thus, statewide application of

the QAP method is likely to result in slightly less net savings of state funds than the existing method. If the special (75%) matching rate for the IOC process is reduced without a proportionate reduction in the matching rate for nursing home reimbursement (see possibility two, Table 12), the QAP method is likely to return greater benefits than the existing method.

3. Nursing homes that "pass" the QAP sampling plan have substantial savings per resident reviewed and thus may represent large sums of unrealized savings.

The rationale behind the sampling approach is that not all residents need to be reviewed to determine whether a home's residents are at the appropriate level of care. While it was found that homes passing the sample have a lower percentage of misclassified residents than existing method homes, homes that failed the sample or homes where the surveyor decided not to sample but instead switched to the existing method, their reimbursement savings were substantial (about \$53 per review per year higher than the existing method and only about \$15 per review lower than homes not sampled, i.e., failed the sample and switched methods). It must be recognized that a considerable proportion (44%) of the reimbursement savings of the QAP method are the result of reviewing residents in homes that pass the sample. If one could assume that the savings resulting from the random sample of residents could be achieved in the non-sampled residents in those same homes, this would have generated an additional \$350,000 in net program savings in 1981 (all funds). This figure represents an estimate of the foregone nursing home reimbursement savings resulting from not reviewing all residents in 1981.

Thus, there is an ambiguity in what the data indicates compared to what would be expected. Homes that pass the sample should not be expected to have high savings per review if indeed sampling effectively screens the "bad" homes. The savings of the homes that pass the sample should be in the vicinity of the existing method since 83% of the homes sampled pass the sample. Possible explanations for the high savings per review in homes passing the sample are:

- a. The sampled residents are not representative of the non-sampled residents in the homes passing the sample.
- b. In reviewing all residents in a home, a fatigue factor might lead to fewer major level of care errors cited.
- c. The intensive review under the QAP method results in a substantial lowering in levels of care.
- d. The adversary relationship between the surveyor and the nursing home is reduced under sampling and in cases where the home passes the sample, the surveyor is more likely to lower levels of care.
- e. The incentive for surveyors to pass a home thus avoiding a 100% review results in atypical level of care changes.
- f. There are differences between surveyors and/or nursing homes under the QAP method versus the existing method.

4. Reviewing private pay residents as is done under the QAP method is costly and does not generate Medicaid reimbursement savings. Private pay IOCs increase the time necessary to conduct resident reviews under the QAP method by about 15%. The other side to this issue relates to the possible quality of care benefits that can accrue to private pay and Medicaid residents and secondly, to increased licensure survey costs since private pay records would then have to be reviewed as part of the licensure survey.
5. Large district and yearly fluctuations exist in the percentage of residents found misclassified and in reimbursement savings. The evaluation being conducted by WHCRI has found agreement on level of care between surveyors to be low.

Other Considerations: Several considerations other than the direct nursing home reimbursement effect should be mentioned as they may impact on the choice between the QAP method and the existing method.

- a. Administrative Order 1.67 - As part of the resident review process, the IOC team may identify residents needing alternate placement or community services. Administrative Order 1.67 formalizes the respective responsibilities of providers, counties and the Division of Health when a resident is so identified. Although the QAP approach contains means for identifying residents in need of alternate placement or community services, since all residents are not reviewed, the ability of the Division to comply with the Order may be limited.

- b. Community Options Program - A Community Options Program (COP) assessment team may review residents in a nursing home to determine alternate placement. The COP statute [s.46.27(2)(b)(2)] requires the Department to ensure coordination between the COP and the IOC process. However, there are no state-specified methods of linkage or coordination. Although it is not clear whether the QAP method or the existing method presents a differing set of problems, the issue of coordination is one that needs to be considered.

- c. A Two Year Survey Cycle - The Department is seeking a waiver of the annual survey requirement under 42 CFR 456.606 which would allow inspections of nursing homes less frequent than once a year. Wisconsin statutes have recently been revised to accommodate this possibility. The likelihood is considerably greater that a two year cycle for facility review will be permitted than will a change in the resident review annual requirement. Since the surveyors who conduct the resident assessment also conduct the certification and licensure survey, there is considerable overlap between the two efforts. In other words, much of the data necessary for the facility survey are obtained as part of the resident review process. Since federal funding at current levels for the facility survey is less likely than for the resident review process, the question arises as to the most advantageous means for funding nursing home quality compliance activities.

- d. Quality of Care - For most homes, the Quality Assurance Project represents less regulation. Little is known about what might happen to the quality of care with a reduction of regulation.

In April 1981, all homes in the LaCrosse, Wisconsin Rapids and Eau Claire districts which had been reviewed under the QAP facility and/or resident review process reverted to the existing facility and/or resident review process. The 1980-81 QAP Annual Report presents data on the number of violations and percent of residents misclassified for 34 homes. In this limited sample, no major differences were found in the number of violations or the proportion of residents misclassified in these homes compared to the existing method homes. In other words, the former QAP method homes neither improved nor deteriorated as measured by violations and level of care errors. It will be important to further document this finding and analyze the issue in greater detail.

Unpublished, but soon to be reported data by WHCRI shows that violations (many of which were considered severe by the WHCRI Team) not found by state survey teams were not corrected, but those that were cited were corrected. WHCRI's own "research team" accompanying the state survey team noted violations overlooked by the state surveyors. Upon follow-up six months later, the violations that were not cited were not corrected whereas the violations that were cited were corrected.¹

Recommendations: This evaluation has analyzed the cost and savings of the IOC review process and based upon this analysis, the following recommendation is made.

¹ Based upon conversation with Professor David Gustafson, principal investigator for the WHCRI evaluation effort.

1. The decision of whether to adopt the QAP approach or the existing method approach should be made on grounds other than financial since there was not a large difference between the two methods in their cost containment potential. However, it must be noted that the IOC process is highly volatile in terms of level of care changes and resulting nursing home reimbursement effects between districts and between years. Thus, there is a need to continue to monitor level of care changes and reassess the savings potential of the IOC process. Moreover, changes in federal matching percentages may make one resident review method more attractive from a financial viewpoint.

In making this decision, several findings of this evaluation that are important to be recognized are: a) the QAP method yields a considerably higher dollar savings per dollar of cost than the existing method; b) the surveyor incentives under the QAP method are complex and may have unintended effects; c) the QAP method lowers levels of care to a greater degree than the existing method; and d) the QAP method's ability to screen "bad" homes is questionable.

Although not specifically tested as part of this evaluation, three other recommendations are offered for consideration:

2. If the QAP method of resident review is adopted, the review of private pay residents should be questioned. All private pay reviews are intensive reviews, increase the cost of the resident review process substantially (15%), provide no Medicaid nursing home reimbursement savings and are likely

to be more efficiently conducted as part of the facility licensure survey. Federal regulations do not require the review of private pay residents as part of the IOC process. As suggested earlier, the potential savings of not reviewing private pay residents must be weighed against the possible quality of care benefits and the cost of reviewing private pay records as part of licensure.

3. Further study is needed to determine the factors that explain the finding of a high savings per review in nursing homes that pass the random sample.

Since a high savings per review exists in homes that pass the sample and since only a sample of residents are reviewed in these homes, the residents not reviewed may represent potentially large unrealized savings. The question arises as to the factors which explain the large savings in the homes passing the sample. To the extent that the savings are due to the intensive review of residents, an increase in the proportion of residents reviewed would result in greater net savings. However, the basis for the intensive review is a quality of care notion involving discussions with nursing home staff. Its impact on the level of care decision would be minor.

It is likely that neither the QAP method nor the existing method are able to effectively capture these unrealized savings. Although not known with certainty, two other factors are speculated to play a significant role. First, the fatigue factor associated with reviewing all or a large number of residents, likely results in a less than complete review and secondly, the

adversary role of the nursing home and surveyor is diminished in the sampling approach and this allows the surveyor greater "freedom" in making appropriate level of care adjustments. Random variation in the data may also be an important factor. Further study is important to help isolate the factors operating in the QAP method. Without an understanding of the effect of these factors, the resident review process will not reach its full cost savings potential.

4. The level of care decision should be made more consistent and predictable.

It was found that level of care decisions and the resulting reimbursement effect varied widely from district to district and between 1980 and 1981. This suggests lack of uniformity in the application of criteria for deciding level of care. To the extent that level of care determination can be made a more consistent process, increased reimbursement savings and a more equitable system should result.

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Further Analysis of
Wisconsin's Nursing Home
Inspection of Care Reviews

Bureau of Evaluation
Division of Policy and Budget

June, 1982



DOCUMENT DIGESTDepartment of Health
and Social Services*Document Title:*Further Analysis of Wisconsin's Nursing
Home Inspection of Care Reviews

This Digest summarizes the above document dated: June, 1982

This report is a follow-up to a recent evaluation of Wisconsin's Inspection of Care (IOC) nursing home resident review process. The intent of this analysis is to further clarify the effects of level of care determination under the federally mandated, 100% review method and the Quality Assurance Project (QAP) sampling method. Persons interested in additional background information are referred to the earlier evaluation entitled "An Analysis of the Effect of Wisconsin's Inspection of Care Reviews on Medicaid Nursing Home Reimbursement: A Comparison of the Quality Assurance Project Approach and the Federally Mandated Approach," which can be obtained from the Division of Policy and Budget.

Two questions are addressed in this report:

1. To what extent are levels of care lowered by IOC reviews and is it true that the QAP method lowers a greater percentage of skilled nursing facility (SNF) care levels than the federally mandated method?
2. Does the incentive for surveyors to pass a home under the QAP sampling plan actually result in fewer homes failing the sample than should?

The first question was addressed through an analysis of almost 17,000 IOC reviews in 358 nursing homes during 1980 and 1981. In this analysis it was found that:

- o The IOC process results in a net lowering of SNF levels of care by 1.4 to 1.9%.
- o The QAP method (sampling) of resident review is likely to result in a net lowering of SNF levels of care four times that of the federally mandated method.
- o Under the QAP method, nursing homes that "pass" the sample have similar percentage reductions in SNF levels as homes that do not pass the sample. This suggests that the QAP sampling method does not adequately identify the homes with level of care problems.

The second question was addressed through an analysis of 34 nursing homes that underwent the QAP sampling method during October, 1981 through April, 1982. In this analysis it was found that:

- o Only one-third as many nursing homes fail the sample under the QAP as expected.
- o Five times as many homes have zero level of care errors as expected.

FURTHER ANALYSIS OF WISCONSIN NURSING

HOME INSPECTION OF CARE REVIEWS

The attached paper is a follow-up to a March 25, 1982, report entitled "An Analysis of the Effect of Wisconsin's Inspection of Care Reviews on Medicaid Nursing Home Reimbursement: A Comparison of the Quality Assurance Project Approach and the Federally Mandated Approach." The interested reader is referred to that report which is available from the Bureau of Evaluation, Division of Policy and Budget, for a summary of the findings and recommendations as well as background information on the Inspection of Care (IOC) process and the Quality Assurance Project (QAP). The attached follow-up report is aimed at clarifying certain issues raised by the first report. At least one other brief follow-up report is expected.

Two questions are addressed in this report:

1. To what extent are levels of care lowered by IOC reviews and is it true that the QAP method lowers a greater percentage of skilled nursing facility (SNF) care levels than the federally mandated method?
2. Does the incentive for surveyors to pass a home under the QAP sampling plan actually result in fewer homes failing the sample than should?

TO WHAT EXTENT ARE LEVELS OF CARE LOWERED BY IOC REVIEWS AND IS IT TRUE THAT QAP
LOWERS A GREATER PERCENTAGE OF CARE LEVELS THAN THE FEDERALLY MANDATED METHOD?

The recent Division of Policy and Budget evaluation of the effect of IOC reviews on Medicaid reimbursement was based on a sample of 320 nursing homes in 1980 and 1981. The changes in the level of care distribution (i.e., the net effect of raising and lowering care levels) before and after the IOC review for these homes is presented in Table 1. The data are separated by method (QAP versus the existing or old or federally mandated method) and within the QAP method the data are further divided into the pass, fail or switch to 100% review options.¹ Only data on Medicaid residents are included, i.e., no private pay residents.

Table 1
Percent Change (Net Differences) in Levels of Care
Before and After IOC Reviews by Method

Level of Care	Existing	QAP				Both Methods
		Total	Pass	Fail	Switch	
SNF	-.2%	-5.8%	-5.6%	-7.0%	-5.0%	-1.4%
ICF-1/2	-1.0%	5.5%	4.6%	7.0%	5.9%	-.4%
ICF-3	6.2%	11.3%	8.1%	8.0%	44.4%	7.4%
ICF-4	13.0%	40.0%	25.0%	55.6%	200.0%	18.3%
No. of Reviews	11,798	3,261	1,570	840	851	15,059
No. of Residents	11,798	12,324	10,633	840	851	24,122
No. of Homes	153	167	138	15	14	320

Note: Several percentages for ICF-4 level of care are based on very small frequencies and thus subject to large random variation. Attachment 1, Table 1.1 contains on which the numbers the percents are based.

¹ As a reminder, the federally mandated method consists of a review of all Medicaid nursing home residents. The terms "existing" or "old" are also used to refer to the federally mandated method. The QAP method samples 20% of all (Medicaid and private pay) residents and if the number of level of care errors found exceeds the criterion, the home fails the sample and all Medicaid residents are reviewed. The option is also available under the QAP method to revert to the federally mandated review method instead of sampling. The March, 1982, evaluation report found that 83% of the QAP homes pass the sample, nine percent fail and eight percent switch to the 100% review.

From this table it can be observed that:

- o The existing method lowers SNF levels of care by only .2% while the QAP method lowers SNF levels by 5.8%.
- o Both methods combined lower SNF levels by 1.4%.
- o Under the QAP method, nursing homes that pass the sample (83% of the homes), lower SNF levels by 5.6%!

Attachment 1, Table 1.1 contains a more detailed table of the numbers on which the percents in Table 1 are based.

Some Bureau of Quality Compliance (BQC) staff were surprised that there were so few SNF levels lowered (in net terms), i.e., 1.4%. It was mentioned that data available from the monthly "Medicaid IOC/PPOC" statistical reports would suggest a larger drop in SNF levels. The following analysis will help explain the difference.

BQC reports for July, 1980 through June, 1981 indicate the following:

No. of IOC SNF reviews	12,668
No. of SNFs lowered	1,254
% lowered	9.9
No. of IOC ICF reviews	12,272
No. of ICFs raised	1,478
% raised	12.0
No. of ICFs lowered	787
<u>% lowered</u>	<u>6.4</u>

As can be seen, 9.9% of the SNF levels are lowered, 12.0% of the ICF levels are raised and 6.4% of the ICF levels are lowered. What is not known but necessary in order to check the comparability between these figures and the ones presented in Table 1 is the percent of ICFs raised to SNF versus the percent of ICFs raised within ICF levels.

To determine the percent of ICFs raised to SNF as well as provide a comparability check between the monthly reports and the data base used to conduct the recent evaluation, IOC reviews for 358 nursing homes were analyzed. This includes the 320 homes used in the evaluation plus 38 additional homes in the rural districts during 1980 and 1981. Table 2 compares level of care changes for the 358 study group and the monthly BQC statistical reports.

Table 2
Level of Care Changes
Study Group Homes and BQC Reports

	Study Group	BQC Reports
% of SNFs lowered	9.6	9.9
% of ICFs raised to SNF	8.8	?
% of ICFs raised to ICF	4.2 } 13.0	? } 12.0
% of ICFs lowered	6.3	6.4
No. of ICF reviews	7,872	12,272
No. of SNF reviews	8,988	12,686

From this table we see that:

- o The level of care changes between the study group and BQC reports in terms of percent of SNFs lowered, ICFs raised and ICFs lowered, are quite similar.
- o For the study group homes, two-thirds of ICFs raised, are raised to SNF.
- o For the study group, for every five SNFs lowered to ICF, there are four ICFs raised to SNF.
- o Applying the percentages from the study group homes to the statewide data indicates for every 10 SNFs lowered to ICF there are nine ICFs raised to SNF.
- o Again, applying the sample percentages to the statewide data, a net decrease in SNFs of only 1.1% is indicated.

Attachment 1, Table 1.2 contains a more detailed table of these findings.

Now that a reasonable comparability has been established between the study group's level of care changes and homes statewide, the data for the 358 home study group are analyzed by method -- the existing method versus the QAP method. Table 3 shows how the methods compare.

Table 3
Level of Care Changes
By Method

	<u>Existing</u>		<u>QAP</u>		<u>Total</u>	
	No.	%	No.	%	No.	%
Level of care error rate	2,076	15.4	313	9.2	2,389	14.2
SNFs lowered	729	10.0	137	8.0	866	9.6
ICFs raised to SNF	640	10.4	54	3.1	694	8.8
ICFs raised to ICF	285	4.6	46	2.7	331	4.2
ICFs lowered	422	6.9	76	4.4	498	6.3
Net reduction in SNFs	89	1.2	83	4.9	172	1.9
No. of ICF reviews	6,156		1,716		7,872	
No. of SNF reviews	7,284		1,704		8,988	
No. of homes	182		176		358	

What can be observed from this table is that:

- o Level of care errors are more frequent under the existing method than under the QAP method (15.4% versus 9.2%).
- o The existing method lowers a greater proportion of SNFs than does the QAP method (10.0% versus 8.0%) but at the same time, the existing method raises a greater proportion of ICFs to SNFs than does the QAP method (10.4% versus 3.1%).
- o The QAP method is likely to result in a net lowering of SNFs that is four times that of the existing method.

Thus, to get back to the original questions of 1) to what extent are levels of care lowered by IOC reviews; and 2) is it true that QAP lowers care levels to a greater extent than the existing method, the following conclusions can be drawn:

1. With regards to the first question, it can be stated with growing confidence that the IOC process (as it was performed during 1980 and 1981), results in a net lowering of SNF levels of care by only about 1.4 to 1.9%.
2. As far as which method lowers levels of care more, the evidence indicates that the existing method lowers SNF levels of care between .2 and 1.2 % while the QAP method lowers SNF levels by 4.9 to 5.8%.

DOES THE INCENTIVE FOR SURVEYORS TO PASS A HOME UNDER THE QAP SAMPLING PLAN
ACTUALLY RESULT IN FEWER HOMES FAILING THE SAMPLE THAN SHOULD?

Under the QAP version of the IOC Process, surveyors review a sample of residents (Medicaid and private pay) rather than all Medicaid residents as is done under the federally mandated method. Depending on the number of incorrect care levels found in the sample, the home will pass or fail the sample. If the home fails the sample, the surveyor must review all residents in the home. Thus arises the notion that an incentive exists for a surveyor to find fewer level of care errors, allowing too many homes to pass the sample. In this way, 100% review is avoided.

To help answer the question noted above, all QAP homes from October, 1981 through April, 1982 with a sample size of 20 were selected for analysis. This group of homes was chosen in order to keep sample size constant in the analysis. Further, nursing homes with a sample of 20 residents reviewed, represent homes with a resident census of 41 to 125 -- the single largest group of nursing homes given

the QAP sampling plan. Nursing homes where the decision was made not to sample, i.e., switched methods, were excluded from the analysis. Thirty-four nursing homes met these criteria and form the basis of this analysis.

For a sample size of 20, three or fewer level of care errors is acceptable and four or more result in a 100% review. The 34 nursing homes contained in this analysis represent 680 resident reviews. In these reviews, 76 level of care errors were detected for an error rate of 11.2%. Four of the 34 or 11.8% of the homes failed the sample. Both statistics, the error rate and the percentage of homes failing the sample are consistent with data collected and reported by the QAP.

To determine whether too few homes fail the sample under the QAP method, one must know how many homes ought to fail. An estimate of the number of homes expected to fail the sample can be derived from properties of the binomial distribution. In order to make this estimate, it is necessary to know the "true" level of care error rate. Using the error rate for the 100% review method as the true error rate, the expected distribution of level of care errors can be calculated.¹ Table 4 compares by number of level of care errors, the actual and expected percentage distributions of homes.

¹ An error rate of 15% is used in this analysis. This error rate is the error rate experienced when IOC reviews are conducted using the 100% or federally mandated review method. If an error of 11.2% was used as the "true" error rate (11.2% was the error rate observed for the 34 QAP homes used in the analysis), the expected percentage of homes with 0, 1, 2, 3 and 4+ errors would be 10.2%, 23.8%, 27.2%, 20.3% and 18.5%, respectively.

Table 4

Actual and Expected Distribution of QAP Nursing Homes
with a Sample Size of 20 by Number of Level of Care Errors

No. of Errors	Actual	Expected
0	20.6	3.9
1	5.9	13.7
2	23.5	22.9
3	38.2	24.3
4+	11.8	35.2
Total	100.0	100.0

From this table, it can be seen that:

- o Only one-third as many homes fail the sample under the QAP as expected.
- o Five times as many QAP homes have zero level of care errors as expected.
- o The proportion of QAP homes with three and only three level of care errors is over one and one-half times the expected proportion.

Thus, based on this brief analysis, the evidence is strong that far fewer homes fail the QAP sample than should.

Table 1.1
Level of Care Distribution
Before and After IOC Review
By Method

Table 1.2
Level of Care Changes
Study Group Homes and BQC Reports

	Study Group		BQC Reports	
	No.	%	No.	%
Level of Care Errors	2,389	14.2	3,519	14.1
SNFs Lowered	866	9.6	1,254	9.9
ICFs Raised	1,025	13.0	1,478	12.0
ICFs Raised to SNF	694	8.8	?	?
ICFs Raised to ICF	331	4.2	?	?
ICFs Lowered	498	6.3	787	6.4
No. of ICF Reviews	7,872		12,272	
No. of SNF Reviews	8,988		12,686	
No. of Homes	358		Statewide	

FURTHER ANALYSIS OF THE EFFECTS OF SAMPLING

A March, 1982, report by the Division of Policy and Budget entitled "An Analysis of the Effect of Wisconsin's Inspection of Care Reviews on Medicaid Nursing Home Reimbursement: A Comparison of the Quality Assurance Project Approach and the Federally Mandated Approach", recommended certain areas where additional research was needed to better determine the effects of the Quality Assurance Project (QAP) method of resident review. To help fill this need for additional information, a follow-up report was issued in June, 1982, that addressed 1) the magnitude of level of care changes under the QAP and federally mandated approaches and 2) surveyor incentives to pass homes under the QAP sampling scheme.

This report further speaks to the need for in-depth analysis and more specifically addresses whether sampling contributes to level of care changes under the QAP method. At least one other brief follow-up report is expected.

Readers interested in background information on the Quality Assurance Project and the Inspection of Care process, are referred to the March, 1982, report available from the Division of Policy and Budget.

TO WHAT EXTENT CAN LEVEL OF CARE CHANGES UNDER THE QAP METHOD OF RESIDENT REVIEW
BE ATTRIBUTED TO AN ARTIFACT OF THE SAMPLING PROCESS?

A June, 1982, report by the Division of Policy and Budget (DPB) concluded that the Inspection of Care (IOC) process resulted in a net lowering of skilled nursing facility (SNF) levels of care by about 1.4 to 1.9%. Further, it was found that the federally mandated, 100% review method (also referred to as the existing method or old method) lowered SNF levels by .2 to 1.2% while the QAP

method lowered SNF levels by 4.9 to 5.8%. For nursing homes that passed the sample, SNF levels were lowered 5.6%. The obvious question that arises is -- why does the QAP method of review lower SNF levels to a greater degree than the federally mandated method?

A number of factors may contribute to the QAP method's greater propensity to lower levels of care. One of several possibilities that was noted in an earlier DPB evaluation was the effects of sampling.

The rationale for the QAP sampling approach is basically an efficiency notion. Rather than review all Medicaid nursing home residents, reviewing a fraction of the residents will, perhaps, achieve the same general results but at a lower cost. Moreover, surveyor time can be diverted from nursing homes providing good care to those providing poor care. The efficacy of the QAP sampling approach came under question when it was found that 1) nursing homes that "passed" the QAP sampling plan lowered SNF levels of care by a similar percentage as those not passing the sample, and 2) only one-third as many homes failed the sample as might be expected. It is possible that reviewing only a sample of residents has created a "sampling environment" that results in biased level of care changes. This sampling environment includes possible unintended effects such as surveyor incentive to pass homes, a reduced adversary relationship between the surveyor and the nursing home and atypical level of care changes resulting from surveyors selecting only the most severe level of care errors.

To help address the question of whether the "sampling environment" plays a role in lowering levels of care, the DPB suggested testing the federally mandated (100% review) review method on a sample basis. To clarify, the federally mandated review method employs a less thorough review than the QAP method. (A QAP review takes twice as long as a review using the mandated approach.) Of course, the QAP method is done on a sample of residents. By applying the less thorough federally mandated review method but on a sample basis, it will be possible to gain insight into the role of the in-depth reviews and the "sampling environment" effects of the QAP method.

The Bureau of Quality Compliance (BQC) implemented sampling under the federally mandated review method during May and June of 1982 in the rural districts (Eau Claire, La Crosse, and Wisconsin Rapids).¹ This experimental sampling method of review will be referred to as the experimental method throughout this analysis.

During May and June, 22 nursing homes were reviewed under the experimental method. Of these 22, 17 passed the sample, one failed the sample (and all Medicaid residents were reviewed) and in four instances, surveyors (based on the home's history) decided to review all Medicaid residents rather than a sample. In all, 501 residents were reviewed in homes eligible for sampling; 265 in homes that passed the sample. Table 1 presents changes in the level of care distribution before and after the IOC review for the 22 homes reviewed under the experimental method.

¹ The review procedure used during this two month time period was the BQC procedure in effect prior to January 4, 1982. A different review procedure has been used since that time. Attachment A outlines the procedures used in the rural districts.

Table 1

Level of Care Changes Under the Experimental
Method, Rural Districts, May/June, 1982

	<u>Total</u>			<u>Pass</u>			<u>Fail</u>			<u>Switch</u>		
	Before	After	%	Before	After	%	Before	After	%	Before	After	%
SNF	222	207	-6.8	120	116	-3.3	46	44	- 4.3	56	47	-16.1
ICF-1/2	255	262	2.7	129	133	3.1	46	40	-13.0	80	89	11.3
ICF-3	24	32	33.3	16	16	.0	3	11	266.7	5	5	0
ICF-4	0	0	-	0	0	-	0	0	-	0	0	-

A question that arises is how do these findings (sampling under the federally mandated method) compare with level of care changes under the QAP method and the federally mandated, 100% review. Table 2 presents the net percent reduction in SNF levels for the three approaches.

Table 2

Net Percent Reductions in SNF the Mandated
(100%), QAP and Experimental Approaches

	<u>Net % SNF Reduction</u>		
	Mandated (100%)	QAP	Experimental
Pass	NA	5.6	3.3
Fail	NA	7.0	4.3
Switch	NA	5.0	16.1
Total	.2-1.2	4.9-5.8	6.8

The pass, fail and switch options, of course, do not apply to the 100% review method. Ranges on the percent reduction in SNFs are presented for the QAP and federally mandated methods (total figures) since earlier evaluation reports produced two estimates.

From these tables, it can be seen that:

- o For all 22 homes eligible for sampling under the federally mandated review method, the net percentage of SNF levels lowered was 6.8%. This is slightly higher than the 4.9-5.8% figure under the QAP method of review.

- o For the 17 homes that passed the sample, the percent reduction in SNF levels was 3.3%. This is lower than the 5.6% under the QAP method and higher than the .2-1.2% estimate for the federally mandated review method.

These results are actually closer to what would be expected under the QAP method if sampling had the intended targeting effect, i.e., homes that pass the sample have lower percentage SNF reductions than those not passing the sample.

Since large district differences in level of care changes are known to exist, the data for the rural districts may not be representative of the state. To provide a district comparison, data for the rural districts in the previous year (May and June, 1981) were tabulated. These homes were reviewed under the federally mandated, 100% review method. The percentage reduction in SNF levels for the 21 rural district homes reviewed during May and June of 1981 was 3.3% (not shown in any tables); lower than the 6.8% for the same period in 1982 but the same percentage as the homes that passed the sample. The 3.3% is also above the .2-1.2% statewide estimate for the federally mandated review method.

Given these various pieces of information, it is not easy to draw a definitive conclusion as to the effect of the "sampling environment" on the QAP method. It is probably safe to conclude that the "sampling environment" contributes to the QAP method's lowering SNF levels of care. How large a contribution, however, is not clear.

Staff of the QAP, BQC have been analyzing data on level of care changes under in-depth and standard reviews.¹ Their preliminary report based on 37 homes found the net percentage reduction in SNFs for in-depth reviews to be only .4% while standard reviews resulted in a 2.4% reduction. If this pattern continues after additional data become available, the case is much stronger that the "sampling environment" is indeed an important factor in explaining the level of care lowering effect of the QAP method. Further, the findings indicate that in-depth reviews are less cost effective than standard reviews.

The major limitation of this study is the small number of homes available for analysis. The volatility in level of care changes found in earlier analyses underscores the importance of this limitation.

¹ As mentioned earlier, a revised BQC resident review process went into effect January 4, 1982. Under this new process, a 10% sample of residents are reviewed using the QAP in-depth review method and the remaining 90% are reviewed using a much briefer (standard) review method. The analysis by the BQC compared level of care changes under the in-depth and standard reviews.

PROCEDURE FOR RURAL SAMPLING

(For use in May and June, 1982, in Districts #5, #6, and #7WR facilities eligible for sampling.)

- | | |
|-----------------------------------|---|
| Nurse and Social Worker Surveyors | 1. Discuss homes for appropriateness of sampling versus full IOC. Use LOC history and QAP Core Criteria. |
| District Support Staff | 2. If decision to sample, put in resident review packet:

-Level of Care Performance Evaluation form
-random number list
-IOC Annual Review form (LTC 8103-001) used prior to 5/7/82
-all other forms necessary for IOC process. |
| Primary Social Worker | 3. Follow QAP A.O. 1.67 procedure. |
| Primary Team | 4. Upon entering facility, apply random number list according to QAP procedure.

5. Complete reviews of residents in sample using IOC Annual Review form according to BQC procedure prior to January 4, 1982. (Average number of reviews to complete per day: RN, 10-12; SW, 12-15.)

6. Complete LOC Performance Evaluation form according to QAP procedures.

7. If sample flunks, complete reviews of all remaining T19 residents as you did under QAP initially (i.e., do same type of review as done for sample).

8. Complete Notice to Provider letter by entering the names of only the T19 residents in the sample. Indicate total number of T19 residents in the facility that would have been reviewed on the top of the Notice to Provider letter.

9. If the sample flunks, use the typed copy of the Notice to Provider form and indicate residents who appeared in the sample by placing the letter "R" in the space to the left of their names. |
| District Support Staff | 10. Staple Notice to Provider and LOC Performance Evaluation form together and include in packet for routing to Central Office, attention: Ronnie Crooks, QAP. |

FACILITY ASSESSMENT

FACILITY/
CITY _____

EVALUATOR _____

DATE _____

OK	A	RESIDENT CONDITION	OK	E	RESIDENT IMPORTANCE
	1	-Personal appearance		1	-Between-resident communication
	2	-Odor		2	-Variety of activities
	3	-Clothing		3	-Residents' lifestyles and conditions matched to activities
	4	-Mood		4	-Facility Activity space
	5	-Awareness		5	-Religious
	6	-Physical condition		6	-Ties to community
	7	-Behavior		7	-Volunteers
	8	-Appropriate safety devices		8	-Ties to family
	9	-Other		9	-Resident Council
OK	B	CARE MANAGEMENT		10	-Staff knows residents; provides some continuity of lifestyle
	1	-Plan of care		11	-Residents' rights respected
	2	-Resident involved in own care		12	-Resident room assignments
	3	-Records system		13	-Handling of problem residents
	4	-Drug system		14	-Orientation program for resident upon admission
	5	-Restorative care		15	-Discharge planning
	6	-Staff attitude toward rehabilitation concepts		16	-Other
	7	-Staff role in planning, evaluation	OK	F	DIETARY
	8	-Evidence of communication among interdisciplinary staffs		1	-Appearance/taste of food
	5	-Other		2	-Food consistency/temperature
OK	C	FACILITY SAFETY		3	-Portions of food; given number of meals a day
	1	-Waiver conditions		4	-Regular and modified diet menus
	2	-New construction/remodeling/usage		5	-Dining area
	3	-Fire safety systems/smoke detectors/sprinklers/fire alarm, etc.		6	-Storage, preparation, handling of food
	4	-Emergency preparedness		7	-Sanitation, maintenance and types of equipment
	5	-Hazards		8	-Other
	6	-Other	COMMENTS (ADDITIONAL SPACE ON BACK)		
OK	D	FACILITY ENVIRONMENT			
	1	-Building/equipment			
	2	-Accessibility of building			
	3	-Patient environment			
	4	-General sanitation			
	5	-Other			

FACILITY ASSESSMENT

Composite

FACILITY/
CITY

TM. COORD.

DATE

N/O*	OK	RESIDENT CONDITION	COMMENTS
		-Personal appearance (groomed/not)	
		-Odor (no problem/problem)	
		-Clothing (appropriate/inappropriate, clean/not)	
		-Mood (happy/glum)(open/afraid to talk)	
		-Awareness (alert/drugged,disoriented-no activity)	
		-Physical condition (good/decubiti, catheters, geri chairs)	
		-Behavior (appropriate/not)	
		-Appropriate safety devices (used/not)	
		CARE MANAGEMENT	COMMENTS
		-Plan of care (goals appropriate/not) (total needs/medical needs only)	
		-Resident involved in own care (yes/negligible)	
		-Records system (meaningful/routine) (self-helpful/only to meet regs)	
		-Drug system (storage,administration appropriate/not correct)	
		-Restorative care (geared to needs/not)	
		-Staff attitude toward rehabilitation concepts (understood, utilized/not)	
		-Staff role in planning, evaluation (periodic reevaluation/ none)	
		-Evidence of communication among interdisciplinary staffs (yes/no)	

ATTACHMENT 15

*N/O-Not Observed

FACILITY ASSESSMENT

Composite

FACILITY/
CITY

TM. COORD. _____ DATE _____

N/O*	OK	RESIDENT IMPORTANCE	COMMENTS
		-Between-resident communication (promote interactions, voluntary gatherings/inhibit, prevent interactions)	
		-Variety of activities (many in and outdoor/TV, bingo only)	
		-Residents' lifestyles and conditions matched to activities (community, facility, bedside/no effort to individualize)	
		-Facility activity space (adequate/inadequate)	
		-Religious (ties to home churches, bedside/no services)	
		-Ties to community (yes/no)	
		-Volunteers (active/little role) (trained/untrained)	
		-Ties to family (aggressive attempt to involve family/no)	
		-Resident Council (resident-run/staff run/no council)	
		-Staff knows residents and provides some continuity of lifestyle (yes/no)	
		-Residents' rights respected (yes/no)	
		-Resident room assignments (appropriate/not)	
		-Handling of problem residents (ok/keep, discharge quickly)	
		-Orientation program for resident upon admission (yes/none)	
		-Discharge planning (pat phrases/individualized)	

DIST: White-D.O.
White-FACILITY
Pink-C.O.
Yellow-HCFA

FACILITY ASSESSMENT

Composite

FACILITY/
CITY

TM. COORD.

DATE

N/O*	OK	DIETARY	COMMENTS
		-Appearance/taste of food (pleasant/all together) (appetizing/unappetizing)	
		-Food consistency/temperature (appropriate/inappropriate)	
		-Portions of food (ample/skimpy) given number of meals a day (seconds, substitutions available/not)	
		-Regular and modified diet menus (nutritionally adequate/not)	
		-Dining area (clean/dirty) (social/regimented)	
		-Storage, preparation, handling of food (appropriate/not)	
		-Sanitation, maintenance and types of equipment (adequate/not)	
		FACILITY ENVIRONMENT	
		-Building and equipment (maintained/not)	
		-Accessibility of building (maintained/not)	
		-Patient environment (temperature maintained/not) (activity space adequate/not)	
		FACILITY SAFETY	
		-Waiver conditions (maintained/not)	
		-New construction/remodeling/usage (does not alter LSC effectiveness/does)	
		-Fire safety systems/smoke detectors/fire alarms/sprinklers, etc. (maintained/not)	
		-Emergency Preparedness (staff knowledgeable, drilled/not)	
		-Hazards (controlled/not)	

*H/O-Not Observed

DIST: White-D.O.
White-FACILITY
Pink-C.O.
Yellow-HCFA

Quality Assurance Project

FACILITY ASSESSMENT

Composite

FACILITY/
CITY

TM. COORD.

DATE

N/O*	OK	STAFF	COMMENTS
		-Number (sufficient/not)	
		-Credentials (appropriate training, qualifications/not)	
		-In-service education (active/not) (academically inquisitive/not)	
		-Mood of staff (self-critical/defensive) (happy/harried)	
		-Attitude toward administration (supportive/critical)	
		-Appearance (neat, clean/sloppy, dirty)	
		-Objectives (interest in improving/just do job) (own goals/not)	
		-Communication (among each other, with resident/little)	
		PROFESSIONAL TIES	
		-Physician(s), medical director (involved/not) (home tries to involve/doesn't)	
		-Transfer of information, inter- and intra-facility (appropriate, timely/not)	
		-Relation with providers of lab/x-ray (good/not)	
		-Quality and source of ancillary personnel, therapists and other (staff/contract) (involved/not)	
		MANAGEMENT	
		-Administrator and Director of Nurses knowledgeable about resident population needs (know geriatric, MR/NI characteristics/don't)	
		-Staff training and evaluation process (active/not)	
		-Focus of policies (resident benefit/facility/code compliance)	
		-Financial management (sufficient supplies, equipment, staff/not) (appropriate resource allocation/not)	
		-Attitude regarding support professionals, committees, etc. (close monitoring/abdication)	

DIST: White-D.O.
White-FACILITY
Pink-C.O.
Yellow-HCFA

Quality Assurance Project

FACILITY ASSESSMENT

Composite

FACILITY/
CITY

TM. COORD. DATE

OK	PHILOSOPHY/GENERAL IMPRESSIONS	COMMENTS
	-Environment (home/institution)	
	-Resident care (total needs/medical needs only)	
	-Resident influence (have input/don't)	
	-Resident strengths/abilities (fostered/ignored)	
	-Importance of community (still part of life/institution now)	
	-Importance of visiting (emphasized/discouraged)	
	-Objectives (care/dollar only)	

COMMENTS:

COMMENDABLE ASPECTS OF FACILITY:

Quality Assurance Project
VOLUNTEER ADMINISTRATOR INFORMATION

Yes, I am willing to participate, and understand the provision of Ch. 50, Wisconsin Statutes prohibiting the disclosure of survey dates to other than authorized state personnel. I understand this agreement is in effect for one year from this date.

SIGNATURE _____ DATE _____

FACILITY _____

ADDRESS _____ ASSN _____

PHONE () _____

Under usual circumstances, I need _____ weeks advance notice to reserve time for the demonstration project.

On the map backing this page, please check those counties in which you prefer not to survey because of traveling distance or because it is too close to your facility.

In the space provided on the back of this page, please list any homes you prefer not to survey because of a possible conflict of interest.

I feel I have some special expertise in the following area(s)

- | | |
|---|---|
| ☐ financial management | ☐ physical plant/environment |
| ☐ personnel management | ☐ community involvement |
| ☐ nursing services | ☐ activities |
| ☐ therapies | ☐ use of support professionals |
| ☐ dietary | ☐ social services |

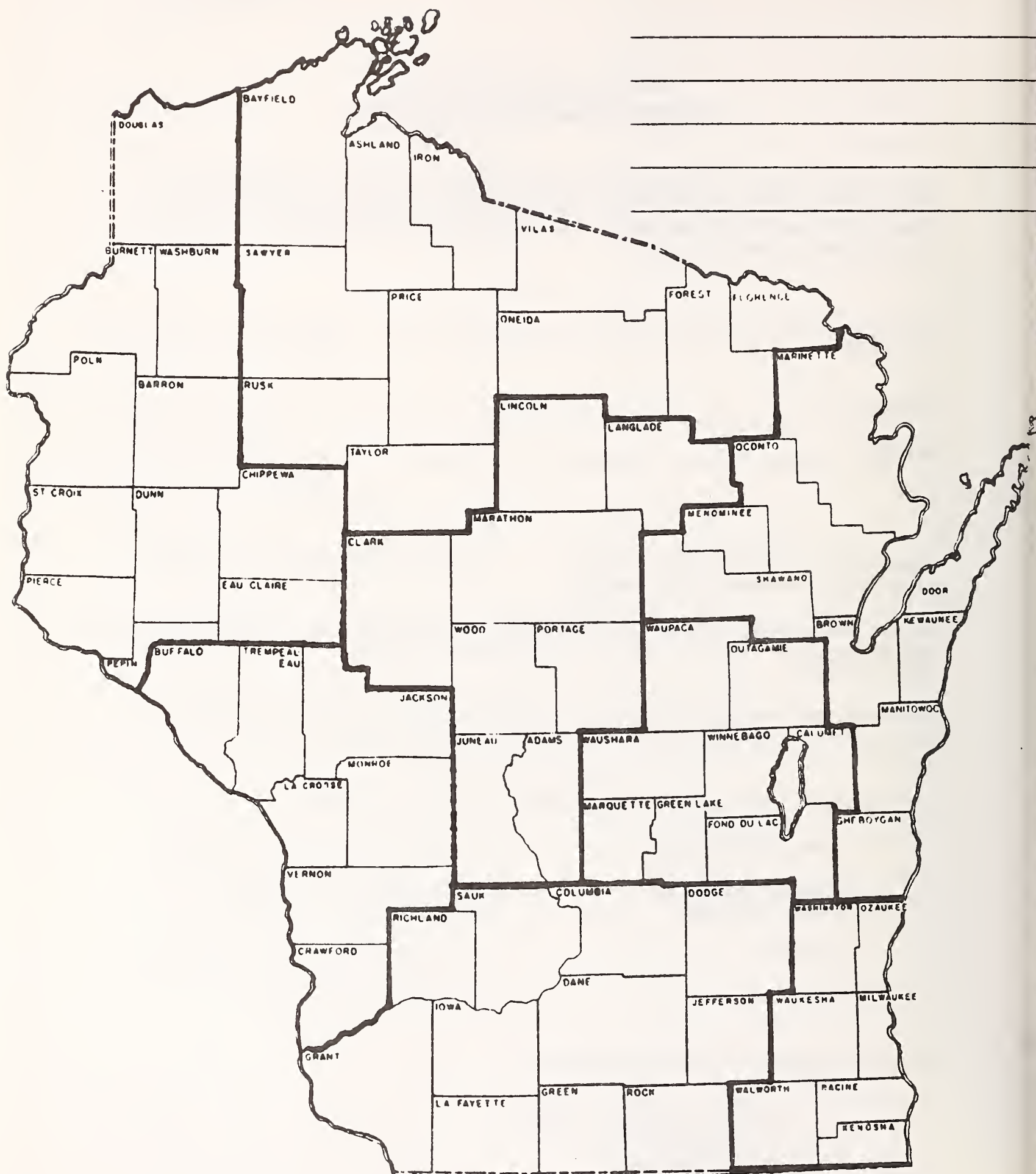
Please complete this form and return to:

Quality Assurance Project
1 W. Wilson St.
P. O. Box 309
MADISON WI 53701

Thank you.

1. Place an X in those counties you do NOT wish to survey.

2. List any facilities you prefer NOT to survey because of conflict of interest



CORRESPONDENCE/MEMORANDUM

STATE OF WISCONSIN

Date: December 12, 1980

File Ref:

To: Judy Fryback

ATTACHMENT 17

From: Joy Stewart

Subject: NHA File Checks/An Update on Criteria

1. Acceptable criteria

- 19 or less total Class C, federal, and problem areas and all corrected, waived, or have POC approved and have made acceptable progress
- spot check on enforcement and forfeitures and nothing is outstanding

2. (a) Borderline criteria--Requires more research

- 20 or more total Class C, federal and problem areas
- any single A's or single B's
- any unpaid forfeitures, from current or previous surveys
- on the Problem Homes list excluding the Special Enforcement section of the list
- is it exception or consistent problems?
- refer to J. Fryback for final approval

(b) Questions to answer in further research:

- If total Class C, federal and problem areas is 20 or more, how many NOV's are due to the physical plant only? How many have been waived?
- What was the nature of the A or B violation?
- If there is any unpaid forfeiture, research the nature of the NOV and record the dollar amount of the forfeiture.
- If a Class A deficiency is cited, was a forfeiture issued? If not, this is an indication of the home's good faith and is positive.
- If a Class B deficiency is cited, was the forfeiture \$100 a day or less? If yes, this is an indication of the home's good faith and is positive.
- Review the annual survey prior to the most current survey and tabulate total NOV's by class by surveyor discipline and problem areas if applicable.

3. Automatic rejection criteria

- Suspension of Referrals/Admissions list
- Surveillance list
- Multiple A's and B's
- Included in the Special Enforcement Unit of the Problem Homes list

JS:jm

Accept ☐
 Review ☐
 Reject ☐

NURSING HOME ADMINISTRATOR FILE CHECK

Administrator _____ Date of Survey _____

Facility _____ QAP Cell _____ Type of Survey _____

License No. _____ District _____

RN

SW

RS

PE

Surveyor's
last name

A

B

C

F

Problem
Areas

Totals

Surveillance _____

SRL/SAL _____

Litigation _____

Comments _____

Accept/Reject _____

Signature _____ Date _____

ATTACHMENT 19

Monthly Summaries of Participation
by Advisory Nursing Home Administrators

<u>Month, Year</u>	<u># Homes Eligible</u>	<u># NHA's Scheduled</u>	<u>% Participation</u>
May, 1978	5	5	100%
June, 1978	5	4	80%
July, 1978	5	4	80%
August, 1978	2	1	50%
September, 1978	3	2	67%
October, 1978	6	6	100%
November, 1978	5	5	100%
December, 1978	3	3	100%
January, 1979	6	5	83%
February, 1979	8	8	100%
March, 1979	6	6	100%
April, 1979	9	9 (1ç)	89%
May, 1979	8	7 (1ç)	75%
June, 1979	7	7 (1ç)	86%
July, 1979	7	7 (1ç)	86%
August, 1979	5	5	100%
September, 1979	3	3	100%
October, 1979	7	6 (1ç)	71%
November, 1979	7	6	86%
December, 1979	5	3	60%
January, 1980	9	5	56%
February, 1980	9	4	44%
March, 1980	5	2	40%
April, 1980	16	9	56%
May, 1980	16	11 (1ç)	63%
June, 1980	12	10 (2ç)	67%
July, 1980	14	11 (1ç)	71%
August, 1980	14	13	93%
September, 1980	12	9 (1ç)	67%
October, 1980	16	16 (3ç)	81%
November, 1980	14	14 (1ç)	93%
December, 1980	10	10	100%
January, 1981	15	13 (2ç)	73%
February, 1981	14	14 (4ç)	71%
March, 1981	10	10	100%
April, 1981	10	10 (1ç)	90%
May, 1981	8	8	100%
June, 1981	7	7 (1ç)	86%
July, 1981	10	8 (1ç)	70%
August, 1981	11	11	100%
September, 1981	9	8 (1ç)	78%
October, 1981	10	10	100%
November, 1981	10	10 (3ç)	70%
December, 1981	8	8 (2ç)	75%

<u>Month, Year</u>	<u># Homes Eligible</u>	<u># NHA's Scheduled</u>	<u>% Participation</u>
January, 1982	9	9 (3ç)	67%
February, 1982	10	10 (2ç)	80%
March, 1982	7	7	100%
April, 1982	7	7	100%
May, 1982	8	8 (2ç)	75%
June, 1982	7	6	86%

ç = cancellation



Quality Assurance Project

SUMMARY OF FINDINGS

- ☐ Annual survey
- ☐ Other survey
- ☐ Follow-up report

DIST: White-D.O.
White-FACILITY
Pink-C.O.
Yellow-H.C.F.A.

ATTACHMENT 20

Facility _____

City _____

Date _____

PROBLEM CARE AREAS - Evidence, Magnitude, Source, Impact on Resident

STATE ACTION/DATE

FACILITY ACTION/DATE

Number each problem to correspond with state and facility action entries. Draw lines to separate problem areas.

State Surveyor _____

Date _____

Facility Representative _____

Date _____

ATTACHMENT 21

Previous Published Reports
of the Quality Assurance Project

Quality Assurance Project, Quarterly Reports

October 31, 1978
February 20, 1979
January - March, 1979
April - June, 1979
July - September, 1979
October - December, 1979
January - March, 1980
April - June, 1980
July - September, 1980
October - December, 1980
January - March, 1981
April - June, 1981
July - September, 1981
October - December, 1981
January - March, 1982

Quality Assurance Project, First Year Report, 1978-1979
Quality Assurance Project, Technical Report, June 1980
Quality Assurance Project, Second Year Report, 1979-1980
Quality Assurance Project, Third Year Report, 1980-1981



RECEIVED NOV 24 1978

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION V175 W. JACKSON BOULEVARD
CHICAGO, ILLINOIS 60604

ATTACHMENT 22

HEALTH CARE FINANCING
ADMINISTRATION

November 13, 1978

Ms. Judy Fryback, Director
Quality Assurance Project
Division of Health
Bureau of Quality Compliance
131 West Wilson Street, Room 905
Madison, Wisconsin 53703

Dear Ms. Fryback:

This is in response to your letter dated October 2, 1978 to Mr. Edward Stec concerning Wisconsin's response to the OPFR's conditions for granting the waiver attached to the Wisconsin Nursing Home Quality Assurance Project. We appreciate your keeping us informed as the demonstration project progresses and would also appreciate receiving copies of all correspondence pertinent to project activities.

At this time we have received several survey packages in which the triage survey process was utilized. My staff has reviewed these files and the following information is provided for your consideration and necessary action.

For the following facilities, the triage survey was completed prior to the July 1 effective date of the waiver approval. Therefore, the recertification for these facilities is not valid. Also, the complete survey package was not forwarded to our office.

<u>Facility</u>	<u>Date of Survey</u>	<u>Type of Facility</u>
Clark County Health Care Center Owen	4/26/78	SNF/ICF
Middle River Health Facility Hawthorne	5/25/78	SNF/ICF
Hetzel Care Center Bloomer	6/8/78	ICF
Piety Place Senior Residence Ellsworth	6/21/78	ICF
Tad Memorial Home Plum City	6/22/78	ICF
Grand View Home Blair	6/28/78	SNF/ICF

<u>Facility</u>	<u>Date of Survey</u>	<u>Type of Facility</u>
River Falls Care Center River Falls	6/28/78	SNF/ICF
Cumberland Memorial Home ECU Cumberland	6/15/78	SNF/ICF
Continental Manor Nursing Home Abbotsford	5/25/78	SNF/ICF

Full surveys of these facilities are to be conducted in accordance with procedures in effect prior to the granting of the waiver. Failure to do so could result in the loss of RFP since the facilities have not been properly certified for participation in the Medicaid program.

There was also a problem concerning either inappropriately completed or missing crucial data element items and/or sheets. In some instances, the entire Life Safety Code portion of the file was missing.

The crucial data element sheets received on the facilities listed above were incomplete. The missing information included:

1. No ICF information;
2. Nurse schedule and staffing pattern not included;
3. Medical Direction items not filled out;
4. LSC crucial data element items sheets not included.

In order for our office to properly process all triage survey packages, the following information is required:

1. Complete triage survey report form for each facility, including the triage checklist, NOV forms for any deficiencies noted, consultation reports and any other relevant documentation;
2. Complete Life Safety Code package and waiver documentation, if any, for each facility;
3. Nurse schedule and Staffing pattern for each facility - pages 24 & 25 of Form SSA-1569;
4. ICF only - Food service staff schedule for each facility - page 24 of Form SSA-3070;
5. 7-Day R.N. and Medical Direction Waivers - complete documentation to support the waiver request;

6. Crucial data element sheets:

The forms designed by your staff have created several problems -

- a. No space is provided for the provider number;
- b. There is no provision for including data relative to food service staff for ICFs;
- c. There are no data tags shown on the form;
- d. It would be beneficial to have ICF and SNF data on separate sheets; this is necessary since SNF and ICF data sheets are processed in a separate manner in our office;

7. Form SSA-1539 (Medicare/Medicaid Certification & Transmittal) is to be completed and submitted for each package;

8. In the "Remarks" - Item 15 section of Form SSA-1539, includes "Triage survey". This is necessary so that our mail procedures may be expedited.

9. Form SSA-1516 (Long Term Care Facility Request to Establish Eligibility in the Medicare And/Or Medicaid Program) from the facility is to be included in each survey package;

Based on the problems encountered we find it necessary to require that the crucial data element sheets provided by our office be completed. Surveyors may continue to use the forms designed by your office but it will be necessary to transpose this data to the required sheets prior to forwarding the package to our office. For your information, we are enclosing copies of these forms.

We would appreciate your obtaining the necessary information and also taking action to ensure that in the future there is a review of the survey package prior to forwarding to our office. If this review is done in the Facilities Regulation Section, that staff is aware of the information needed and of their responsibility to perform a total review of the package prior to recertifying the facility and forwarding the package to our office. If this review is to be done by project staff, someone should be designated as responsible for package review and should familiarize themselves with our requirements.

We would be happy to meet with you to discuss this matter further. Should you have any questions, please call Ms. Betty Barnes at 312-353-3225.

Sincerely yours,



Richard A. Hall, Pharm. D.
Director

Division of Survey & Certification Operations
Regional Health Standards & Quality Office

Enclosure

Intermediate Care Facility Survey Report
Crucial Data Extract

To Be Used With Forms SSA-3070 & SSA-3070D

Total Facility

T1: _____ T5: _____
*Provider No. Facility Name *Survey Date

Transcribe the Following
Crucial Data Elements
From Form SSA-3070

* T9 _____ T101 (1) ☐
* T10 _____ (2) ☐
T11 _____ (3) ☐
* T98 (1) ☐ (2) ☐ (3) ☐ (4) ☐
T99 _____
T100 _____

NOTE

*ATTACH COPY OF PAGE 24 OF
FORM SSA-3070

Distinct Part Facility

T301: _____ T304: _____
*Provider No. Facility Name *Survey Date

Transcribe the Following
Crucial Data Elements
From Form SSA-3070D

*T343 (1) ☐ (2) ☐ (3) ☐
T344 _____
T345 _____

Skilled Nursing Facility

HEALTH SURVEY FORM

(For Reporting Crucial Data Elements)

F1: _____
*Provider No.

Facility Name

F5: _____
*Survey Date

Transcribe the Following
Crucial Data Elements
From Form SSA-1569

*F10 _____

*F11 _____

*F12 _____

*F91 (1) ☐ _____

(2) ☐ _____

*F92 (1) ☐ (2) ☐

F93 _____

NOTE

* ATTACH XEROX COPIES OF PAGES
24 AND 25 OF FORM SSA-1569

FIRE SAFETY SURVEY

(For Reporting Crucial Data Elements from Form SSA-2786)

*Provider No.	Facility Name	*K4: Survey Date																																																				
*K3 A. _____ B. _____ C. _____		*K64 <table border="1" style="width: 100%; border-collapse: collapse; text-align: center;"> <thead> <tr> <th></th> <th>(1) AES</th> <th>(2) S</th> <th>(3) N/A</th> </tr> </thead> <tbody> <tr><td>(a)</td><td></td><td></td><td></td></tr> <tr><td>(b)</td><td></td><td></td><td></td></tr> <tr><td>(c)</td><td></td><td></td><td></td></tr> <tr><td>(d)</td><td></td><td></td><td></td></tr> <tr><td>(e)</td><td></td><td></td><td></td></tr> <tr><td>(f)</td><td></td><td></td><td></td></tr> <tr><td>(g)</td><td></td><td></td><td></td></tr> <tr><td>(h)</td><td></td><td></td><td></td></tr> <tr><td>(i)</td><td></td><td></td><td></td></tr> <tr><td>(j)</td><td></td><td></td><td></td></tr> <tr><td>(k)</td><td></td><td></td><td></td></tr> <tr><td>(l)</td><td></td><td></td><td></td></tr> </tbody> </table>		(1) AES	(2) S	(3) N/A	(a)				(b)				(c)				(d)				(e)				(f)				(g)				(h)				(i)				(j)				(k)				(l)			
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(j)																																																						
(k)																																																						
(l)																																																						
*K6 A. ☐ 1. ☐ 2. ☐ 3. ☐ B. ☐																																																						
*K9 A. 1. ☐ 5. ☐ 2. ☐ 6. ☐ 3. ☐ 7. ☐ 4. ☐ 8. ☐																																																						
*K10 B. _____ K11 C. _____																																																						
*K12 D. ____ / ____ MM YY																																																						
K38 1. ☐ 2. ☐ 3. ☐																																																						
*K47 1. ☐ 2. ☐ 3. ☐																																																						
K48 1. ☐ 3. ☐ 2. ☐ 4. ☐																																																						
K49 _____																																																						
*K50 1. ☐ YES 2. ☐ NO 3. ☐ N/A																																																						
K52 ____ / ____ / ____																																																						
K53 _____																																																						
		Recommendation for Waiver (Code Data Tags With / As Separator)																																																				
		K80:																																																				
		1973 Fire Safety Survey																																																				
		☐ K81:1#																																																				

 State of Wisconsin \ DEPARTMENT OF HEALTH AND SOCIAL SERVICESDIVISION OF HEALTH
BUREAU OF QUALITY COMPLIANCEQuality Assurance Project
131 West Wilson Street Room 905
Madison, Wisconsin 53703

DATE: March 7, 1979

TO: Betty Barnes, Div. of Survey & Certification Operations

VIA: Dick Hall, Director, Div. of Survey & Certification Operations

FROM: Judy Fryback, Director *jk*
Quality Assurance Project

SUBJ: Documents Related to Pre-Waiver Homes

We are happy to enclose the documents you requested in your February 7, 1979 letter. This concludes our part in compiling missing data for the thirteen pre-July 1978 surveys.

We appreciate your review of this information in order to discuss your recommendations with Martin Stanton. I look forward to receiving a decision on the resolution of this matter.

The attached tables list the data we are sending. Please call if you have any questions.

I am assuming that other concerns about reporting procedures expressed in that letter will be resolved at the March meeting with personnel from the bureau's Facilities Regulation Section.

JF:dls

xc: Charles Fiss, Jr.
Milt Stearns

DATA SENT TO REGION V
(Sent March 7, 1979)

	Medical Direction Items	ICF Crucial Data Elements	Nurse Schedule and Staffing Patterns	Life Safety Code Crucial Data Elements	Food Service Staffing Schedule
✓ Middle River Health Facility, Hawthorne	R X				
✓ Cumberland Memorial Home ECU, Cumberland		R X			
✓ Grandview Home, Blair			R X		
✓ Knapp Haven, Chetek		R X	R X		
✓ Piety Place, Ellsworth				R X	R X
✓ Hetzel Care, Bloomer				R X	R X
✓ St. Michael's Lutheran Home, Fountain City					R X

R = Requested by Region V

X = Sent this mailing

DATA SENT TO REGION V

(Sent March 7, 1979)

Facility Assessment pp. 1-7

worksheets

BQC/QAP-3/78:FA

[illegible]

* Asterisked forms are not received by the facilities.

Facility Assessment pp. 1-7
worksheets
BQC/QAP-3/78:FA

		Licensure	Summary of Findings on Facility Assessment BQC/QAP-3/78:S	RN Report *	SW Report *	RS Report *	Special Advisor Report*	Nursing Home Administrator Report*	Nursing Home Administrator/ Special Advisor Findings BQC/QAP-5/78:NHA/SAF or BQC/QAP-4/78:NHAF *	Administrator's Evaluation of New Survey methods	Consultant Referral* FAS 9/75	Consultant Report* FAS 9/75	Surveyor In-service/Consultation Report BQC/QAP:SICR-7/78*	Surveyor Consultation Evaluation BQC/QAP-5/78:SCE*	Nursing Home Consultation Evaluation BQC/QAP-5/78:NHCE*	Summary of Findings p.2, Follow-up report BQC/QAP-5/78:S*	Miscellaneous Reports
Grandview, Blair	SNF	1	3	1	1	1	1	1	1	1	2	2	-	1	1	3	1
Knapp Haven, Chetek	SNF	1	1	1	1	1	1		2	1	4	2	-	2	3	-	2
Capeside Cove, Siren	ICF	1	1	1	1	1	1	1	1	1	2	2	-	1	2	-	1
Hillview, La Crosse	SNF	1	2	1	1	1		1	1	1	2	2	-	-	-	2	1
Hetzel Care Center Bloomer	ICF	1	2	1	1	1		1	1	1	1	1	-	-	1	-	1
River Falls Care Center River Falls	SNF	1	1	1	1			1	1	1	1	1	1	-	-	-	1

* Asterisked forms are not received by the facilities.



ATTACHMENT 24

RECEIVED

OCT 22 1979

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGION V

175 W. JACKSON BOULEVARD
CHICAGO, ILLINOIS 60604

DIVISION OF HEALTH

HEALTH CARE FINANCING
ADMINISTRATION

October 19, 1979

Mr. Robert Durkin
Administrator
Division of Health
P.O. Box 309
Madison, Wisconsin 53701

Dear Mr. Durkin:

During the meeting of September 21, 1979 concerning the Wisconsin Quality Assurance Project, the question was raised regarding resolution of the State's usage of the triage survey process in thirteen nursing homes prior to the project's July 1, 1978 effective date. As you were advised, we have determined that the facilities did meet all the Conditions and Standards for Participation in the Medicaid program and are considered to have been validly certified for the term of the provider agreement. Therefore, no further action is necessary on the part of the State Agency.

Should you have further questions concerning this matter please call me at 312-353-8953.

Sincerely yours,

Richard A. Hall, Pharm. D.

Director

Division of Survey & Certification
Operations

Regional Health Standards & Quality
Office

January 13, 1982

Ms. Baulah Behrens
Quality Control Division
Region V, HSS
175 W. Jackson, 9th Floor
CHICAGO IL 60604

Dear Ms. Behrens:

I understand you recently spoke with Judy Fryback, Director of the Quality Assurance Project (QAP), concerning our proposal to modify reporting of QAP data on the Quarterly Showing. As a result of your favorable response, we will be implementing these changes in the January - March, 1982 Quarterly Showing.

As you know, the revised reporting provides all project statistics on the Quarterly Showing and eliminates an additional report submitted to your office (Attachment I). One change, made at your request, is to explain the use of the asterisks on each page of the Quarterly Showing. I have attached a complete packet outlining all changes (Attachments II, III).

I would like to thank you for your assistance in this matter and appreciate your willingness to accommodate the different reporting requirements of the project.

Please call Judy Fryback at (603) 266-3449 if you have questions or would like further information.

Sincerely,

Peggy Ann Smelser
Director
Bureau of Quality Compliance

PAS:PB:kk 497665

Attachments (3)

cc: -D. Jehl
-M. Preizler
-D. Cooperrider
-J. Fryback
-E. Cornelius
-J. Spatz
-L. Remily

No Notice to Provider is issued unless a full review is done - If review is failed, full review is done and Notice filled out at that time.

Facilities Receiving New Resident Assessment

Facility	R.A. Coordinator	Date Completed	#MA Reviewed	# In Sample	Total M
<u>April, 1981</u>					
<u>DISTRICT #1</u>					
*Colonial Manor N.H. Madison N52507402	D. Scheide, R.N.	4/11/81	6	15	118
Caravilla Beloit N52503104	R. Benzie, R.N.	4/17/81	10	21	124
*Southwest H.C. Cuba City E80000693	D. Scheide, R.N.	4/24/81	8	10	39
Clinton Meadows Clinton N52552309	K. Hopson, R.N.	4/29/81	6	10	44
Ingleside Mt. Horeb N52552200	A. O'Donnell, R.N.	5/1/81	9	12	69
Orchard Manor-North Lancaster N52586505	Tom Swant, S.W.	4/3/81	14	16	91
*Orchard Manor-South Lancaster N52586505	E. Lutz, R.N.	4/22/81	10	10	58
Parkview Terrace Platteville N52521908	F. Martin, R.N.	4/17/81	8	10	46
<u>DISTRICT #2</u>					
Hillview N.H. Milwaukee N52562209	B. Temperly, R.N.	4/23/81	6	11	63
Parkview Care Ctr. Milwaukee E80000404	J. Preston, R.N.	4/15/81	10	10	67

* indicates full review done

Quarterly Showing - Revised Reporting Procedures

Facilities identified with one asterisk. *

This denotes that:

- a sample was completed in place of the full T19 review;
- the sample passed;
- no additional residents will be reviewed for level of care determinations;
- the required information from the sample will be listed in Column II on the Quarterly Showing form;
- the information will list the
 - .exit date of the sample,
 - .number of T19 residents in the sample (____R),
 - .total number of residents in the sample (____S),
 - .total number of T19 residents in the facility (____MA).

Facilities identified with two asterisks. **

This denotes that:

- a sample was completed;
- the sample failed;
- the required information from the sample will be listed in Column II on the Quarterly Showing form;
- the information will list the
 - .exit date of the sample,
 - .number of T19 residents in the sample (____R),
 - .total number of residents in the sample (____S),
 - .total number of T19 residents in the facility (____MA),
 - .the exit date of the full T19 review below the sample breakdown in the quarter in which it is completed.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Health Care Financing Administration

QUARTERLY SHOWING

Quarter Ending _____ Facility Listing for _____ (Level of Care) Page _____ of _____ State _____

COLUMN I	COLUMN II	COLUMN III +	COLUMN IV	COLUMN V	COLUMN VI	COLUMN VII
Facility Name Address Provider Number	Certification Status Change	Reviews com- pleted in Prior 12 Months	PSRO Assumption Date/Area	PSRO Relieved Date/Area	Team Leader and Degree	Level of Care S=SNF, I=ICF, SI=SNF/ICF
* Nursing Home A Address City Provider Number		Date R, ____ S, ____ MA				
** Nursing Home B Address City Provider Number		Date R, ____ S, ____ MA Date				

*Facility sampled and passed; **Facility sampled and flunked.

+First Date = Sample exit, ____ R = # T19 in sample, ____ S = # residents in sample, ____ MA = # T19 residents in facility,
last date = INC exit

ADVISORY PANEL PARTICIPATION

NAME	DATE OF MEETING	11/78	12/78	1/79	2/79	4/79	10/79	2/81	5/82
Rick Shannon, R.Ph. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Jerry Cabala, A.C.S.W. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Jan Stovall, Sp.H.C. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Laura Braunel, O.T.R. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Bev Krueger, R.N. Bureau of Quality Compliance		/	✓	✓	on leave				
Alfred Dally, M.D. Bureau of Health Care Financing		/	✓	✓	✓	✓	✓		
Frances Koonce, R.N. Bureau of Health Care Financing		/	✓	✓	✓	✓	✓		
Philip Utz, M.D. Contract IMR Physician		/	✓	✓	✓	✓	✓	✓	✓
Martha Schram, P.T. University of Wisconsin		/	✓	✓	✓	✓			
John Ederer, N.H.A. Maplewood-Sauk Prairie		✓	/	/	✓	✓	✓	✓	✓
David Green, N.H.A. Evergreen Manor		✓	/	/	✓	✓	✓	✓	✓
Dale Pauls, N.H.A. Pine Valley Manor		✓	/	/	✓	✓	✓	✓	✓
Joy Moy, R.N./N.H.A. Lincoln Lutheran		✓	/	/	✓				
Tom Rand, N.H.A. Bethany--St. Joseph		✓	/	/	✓	✓	✓	✓	✓
Maynard Schubring, N.H.A. Marathon County		✓	/	/	✓				
Jim Zoromski, N.H.A. Oshkosh Care Center		✓	/	/					
Mel Sensenbrenner, P.E. Bureau of Quality Compliance				✓	✓	✓			
Eleanor Irwin, R.D. Bureau of Community Health				✓	✓	✓			
Karen Neaves, R.N. Maplewood-Sauk Prairie					✓	✓			
Maureen Andren, P.T. Madison							✓	✓	✓
Scheryl Schmeltz, R.N. Dean Clinic								✓	✓

✓ = invited
 / = not invited
 — = not active on panel

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
Health Care Financing Administration

QUARTERLY SHOWING

Quarter Ending _____ Facility Listing for _____ (Level of Care) Page _____ of _____ State _____

COLUMN I	COLUMN II	COLUMN III +	COLUMN IV	COLUMN V	COLUMN VI	COLUMN VII
Facility Name Address Provider Number	Certification Status Change	Reviews com- pleted in Prior 12 Months	PSRO Assumption Date/Area	PSRO Relieved Date/Area	Team Leader and Degree	Level of Care S=SNF, I=ICF, SI=SNF/ICF
* Nursing Home A Address City Provider Number		Date R, ___ S, ___ MA				
** Nursing Home B Address City Provider Number		Date R, ___ S, ___ MA Date				

*Facility sampled and passed; **Facility sampled and flunked.

+First Date = Sample exit, ___ R = # T19 in sample, ___ S = # residents in sample, ___ MA = # T19 residents in facility,
last date = IOC exit.

ADVISORY PANEL PARTICIPATION

NAME	DATE OF MEETING	11/78	12/78	1/79	2/79	4/79	10/79	2/81	5/82
Rick Shannon, R.Ph. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Jerry Cabala, A.C.S.W. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Jan Stovall, Sp.H.C. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Laura Braunel, O.T.R. Bureau of Quality Compliance		/	✓	✓	✓	✓	✓		
Bev Krueger, R.N. Bureau of Quality Compliance		/	✓	✓	on leave				
Alfred Dally, M.D. Bureau of Health Care Financing		/	✓	✓	✓	✓	✓		
Frances Koonce, R.N. Bureau of Health Care Financing		/	✓	✓	✓	✓	✓		
Philip Utz, M.D. Contract IMR Physician		/	✓	✓	✓	✓	✓	✓	✓
Martha Schram, P.T. University of Wisconsin		/	✓	✓	✓	✓			
John Ederer, N.H.A. Maplewood-Sauk Prairie		✓	/	/	✓	✓	✓	✓	✓
David Green, N.H.A. Evergreen Manor		✓	/	/	✓	✓	✓	✓	✓
Dale Pauls, N.H.A. Pine Valley Manor		✓	/	/	✓	✓	✓	✓	✓
Joy Moy, R.N./N.H.A. Lincoln Lutheran		✓	/	/	✓				
Tom Rand, N.H.A. Bethany--St. Joseph		✓	/	/	✓	✓	✓	✓	✓
Maynard Schubring, N.H.A. Marathon County		✓	/	/	✓				
Jim Zoromski, N.H.A. Oshkosh Care Center		✓	/	/					
Mel Sensenbrenner, P.E. Bureau of Quality Compliance				✓	✓	✓			
Eleanor Irwin, R.D. Bureau of Community Health				✓	✓	✓			
Karen Neaves, R.N. Maplewood-Sauk Prairie					✓	✓			
Maureen Andren, P.T. Madison							✓	✓	✓
Scheryl Schmeltz, R.N. Dean Clinic								✓	✓

✓ = invited
 / = not invited
 — = not active on panel



FACILITY ENVIRONMENT INFORMATION

ATTACHMENT 27

FACILITY NAME _____

DATE _____

Surveyor Signature _____

1. Dates of local fire inspection documentation (last two).

2. Date of sprinkler system certification, if required _____
3. Date of last annual fire extinguisher inspection _____

Check if documentation exists for the following:

- ☐ 4. Fire drills and inservice for each shift quarterly.
- ☐ 5. Fire and disaster plan reviewed and updated annually.
- ☐ 6. Emergency generator tested (monthly and load tested quarterly).
- ☐ 7. Emergency water supply agreement (Sif only).
- ☐ 8. Weekly fire and smoke alarm test.

Check if any of following observed:

- ☐ 9. Obstruction of exit doors and exit corridors.
- ☐ 10. Hooks or locks on patient room and exit doors.
- ☐ 11. Wedges under stairwell doors, doors difficult to latch upon closing, missing "fire door - keep closed" signage.
- ☐ 12. Exit signs not illuminated.
- ☐ 13. Patient room doors do not latch positively (roller latches require 15 lbs. pressure), have transfer grilles, operative transoms.
- ☐ 14. Smoke doors obstructed (wedges, blocked open), do not close tightly when released.
- ☐ 15. Unshoveled snow or ice at exit sidewalks.
- ☐ 16. Fire doors obstructed (wedges, hold-open devices, blocked open), do not latch positively upon closing (laundry, kitchen, storage, O.T., boiler room, soiled linen, locker rooms).
- ☐ 17. Oxygen storage room not ventilated, tanks unanchored.

- ☐ 19. Extension cords with multiple outlets.
- ☐ 20. Smoking permitted in undesignated areas.
- ☐ 21. Combustible wastebaskets (rated plastic or steel only).
- ☐ 22. Combustible liquids stored improperly (gasoline in power mowers, snow blowers, etc. located in building).
- ☐ 23. Peeling paint, rotting wood, spalling brick joints, settling sidewalks, broken or missing screens.
- ☐ 24. Missing tile, cracked or peeling walls, leaking faucets, cracked or broken windows, loose handrails.
- ☐ 25. Inoperable nurse call (check with nursing staff).
- ☐ 26. Exhaust fans not functioning (soiled linen, utility rooms, toilets, janitors' closets).
- ☐ 27. Lack of cubicle curtains, privacy screens and drapes.
- ☐ 28. Inadequate space for lounge and sitting area (conflicts with other space use).
- ☐ 29. Facility has had any construction, remodeling, new carpet, new drapes in the past year or change of room usage.

Check if:

- ☐ 30. Any new construction or remodeling is planned.
- ☐ 31. Any patients on second floor not ambulatory.
- ☐ 32. Facility has had any incident of fire within the past year.
- ☐ 33. No elevator inspection and maintenance contract.
- ☐ 34. Hot water temperature _____.
- ☐ 35. Room temperature during day _____.
- ☐ 36. No. of patients _____, beds set up _____.

MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION V - CHICAGO

DATE: June 15, 1979

ATTACHMENT 28

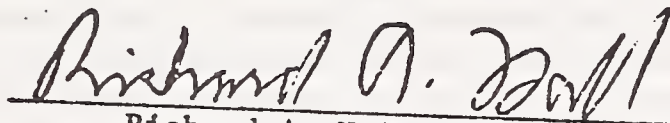
TO: Project Officer
OPPR

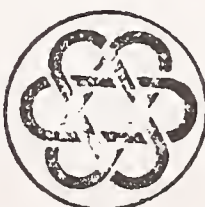
FROM: Director
Division of Survey & Certification
Operations
Regional Health Standards & Quality Office

SUBJECT: Wisconsin Quality Assurance Project

The following summarizes our recommendations regarding extension of the Wisconsin Quality Assurance Project for the second year:

1. We recommend approval of the waivers for this project's second year.
2. We recommend addition of the Life safety code triage to this project.
3. We do not recommend expanding the project State-wide, as evaluation to date is not complete enough to warrant such expansion. In addition, several issues remain to be resolved with the project director, as outlined in our memorandum of May 22, 1979.


Richard A. Hall, Pharm. D.



MEMORANDUM

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
REGION V — CHICAGO

TO : Project Officer
OPPR

DATE: May 22, 1979

Director
DSCO

FROM :

SUBJECT: Your Memorandum - Review of Non-Competitive Continuation of
11/9/97029-5-2, Wisconsin Nursing Home Quality Assurance Project

In response to your memorandum we have reviewed Wisconsin's request to continue the Nursing Home Quality Assurance Project in the State. The following represents our comments and concerns relative to the continuation of the project as well as those issues which were discussed when the project was initially proposed and which we feel still require resolution.

The Wisconsin Nursing Home Quality Assurance Project was approved as a waiver only project for the period July 1, 1978 through June 30, 1979. Since that time our office has assumed responsibility for monitoring the project's survey and certification activities in accordance with our responsibilities to monitor this aspect of the Title XIX program. Our activities to date include the evaluation of several survey packages in which the triage survey process was utilized. We have not, however, finished the complete evaluation of these surveys and a separate report of this analysis will be provided when our review activity is completed. Within the next few months, our Program Review Branch will conduct onsite comparative surveys of Wisconsin Nursing homes which have been surveyed by the State Agency utilizing the triage survey method. The Federal surveyors will conduct a complete survey to determine compliance with all Conditions of Participation for skilled nursing facilities and standards for intermediate care facilities; the survey will be done within sixty days of the State survey and a comparison will be done with the State findings.

As you can see, our evaluation of the triage survey process in Wisconsin is in its initial stages and is expected to continue for some time. For this reason, based on our initial impressions, we are not able to provide a complete objective evaluation of the project's activities and/or results. Therefore, we would recommend that the project waiver be renewed for another year, including the expansion in the Life Safety Code area. However, we do not recommend that the project be expanded State-wide, as proposed to be implemented by January, 1980, until such time as our office and Central Office staff have had an opportunity to perform the complete evaluation of the project.

The primary goal of the project is to improve the quality of care in nursing homes in the demonstration areas using cost effective techniques which reallocate the State's resources. However, the project is not designed to save costs, only to reallocate the State's resources, since there is no reduction indicated in the State's survey staff. We would also like to point out that any expansion of the project should be allowed only if the evaluation efforts now in progress clearly indicate that there has been no decline in the quality of care provided to the nursing home residents.

The request for continuation of the waiver also proposed that the architect-engineer employ a screening technique complementary to the facility screening technique in surveying for the Physical Environment Condition of Participation. While we recommend approval of this aspect of the project, the following issues should be resolved:

1. A screening tool similar to that utilized for the health portions of the survey should be developed;
2. Terms such as "largely in compliance", "regression of prior compliance" should be elaborated on and defined;
3. The facility selection criteria need to be fully described and defined;
4. Basic ground rules should be developed for all surveyors; clarify steps in selecting a facility and determining at what point a full survey is required to provide some control and consistency for the process.

Finally, when the project was originally proposed, our office forwarded our comments and recommendations as well as a summary of issues requiring resolution and problems already noted and possible Regulatory conflicts (copy attached). At this time, the following issues still have not been resolved:

Attachment I

Public Disclosure Requirements

The issue of the release of triage survey documents for public inspection has not been resolved.

Utilization of consultants

From the information provided our office, we are unable to determine if the process has in fact provided for speedy communication of problems to the facility enabling resolution through consultation rather than citation of deficiencies and obtaining an appropriate plan of correction.

Subjective Surveyor Judgment - Facility Bias

Although it was indicated that this issue would be dealt with in the original proposal and is again referred to in the waiver request, we have not been provided with any information as to how this was or is being done.

Facility Classification Criteria - "Good", "In need of consultation", "In need of enforcement action".

This issue has been not resolved, objective criteria reflecting how facilities are categorized has not been provided.

Terms - "Quality of Care" Definition

In order to improve quality of care, it is necessary to define specifically what is meant by this term, its implications and the specific factors which are to be included in such a term. This has not been done.

Regulation Classification

HEW requested how the project had classified Federal Regulations into the five categories identified, important, important for some patients, unnecessary, unclear and duplicative. This classification has not been provided.

Survey Methodology - Consultation process, Statements of deficiencies, Plans of Correction. From the preliminary review of several triage survey packages, it appears that deficiencies are not being cited when a home is found to have problems and consultation is provided. In our opinion, if a standard is found to be deficient this fact should be cited as a deficiency and a plan of correction obtained. This matter becomes particularly important in the event the same standard is still deficient on a subsequent survey, such situation requiring appropriate termination action.

Attachment 2

Triage Survey Instrument

There are no guidelines outlined for the criteria used on the form. Many of the criteria are subjective and difficult to judge, particularly given the small amount of time which will be spent in the facility on a triage survey. It would be helpful to have more specific definitions or guidelines for some of the terms used in order to judge whether these areas are adequately covered. The project manual does not contain these guidelines.

The triage survey does not address or adequately cover the following areas:

Medical Direction 405.1122 - not covered

Nursing Services 405.1124

Conformance with physician's drug orders

Storage of drugs and biologicals

Rehabilitative nursing care

Supervision of patient nutrition

Dietary 405.1125

Therapeutic diets

Specialized Rehabilitative Services 405.1126 - not covered

Pharmaceutical Services 405.1127 - not covered

Laboratory and X-Ray Services 405.1128 - not covered

Dental Services 405.1129 - not covered

Infection Control 405.1135

Asceptic and isolation techniques

Linen

Pest control

Utilization Review 405.1136 - not covered - except for discharge planning

A handwritten signature in cursive script, reading "Richard A. Hall", written over a horizontal line.

Richard A. Hall, Pharm. D.

Attachments

Role of the Engineer in Quality Assurance Project Screening Survey

Attached you will find an expanded explanation of the role of the engineer in the Quality Assurance Project's (QAP) screening surveys. The engineer's role was developed in stages over the past few months with input from a variety of individuals. Beginning in July, 1979 after approval of the QAP waiver proposal, QAP staff members began regular meetings with Steven Schlough, Section Chief, Facilities Need Analysis, Bureau of Quality Compliance, to flesh out the engineer's role in screening surveys as outlined in the original proposal.

A draft of the engineer's role was circulated to all eleven architect/engineers in the Facilities Need Analysis section for their critique and comment. A more detailed version of the engineer's role was developed from their feedback.

Training in QAP survey methodology was held September 24 - 27, 1979 for six architect/engineers from the demonstration districts. Day one included orientation to the project philosophy, the team concept and facility screening process. Mock strategy sessions were held with two nurses, a social worker and a sanitarian to discuss the history of two facilities that had been selected for a "dry run" of the methods. The architect/engineers divided into two groups and planned their strategy for the following day.

On day two, the architect/engineer surveyors arrived at two area facilities and met with facility staff, screened, drew up documentation and presented findings to the nursing home staff. During this time, QAP staff and Steven Schlough monitored their approach to the new methods, asked and answered questions, and recorded procedural problems needing further development.

At a "debriefing" session the following day, areas of concern were identified and discussed. The architect/engineers shared strategies which worked well and made suggestions about forms and documentation.

Since that time, QAP staff met with each of the QAP-trained architect/engineer surveyors to compile a more comprehensive explanation of the engineer's role in screening and follow up. This explanation (attached) will form the basis for a major revision in the QAP procedure manual, necessitated by approval to screen for the Life Safety Code.

We have asked for continued input from the engineers over the next three months to identify and resolve problems as yet unaddressed. QAP's Field Administrator will observe each of the engineers on a screening survey during that time. We anticipate having a refined procedure by December 1979.

ROLE OF THE ENGINEER IN THE QAP SCREENING SURVEY

Before the Survey

1. Before the district scheduling meetings, the engineer will review the history of the home's physical condition and disaster preparedness from the previous year's survey packet and the computer profile of the facility. In homes eligible for either the new facility assessment/new resident assessment (n/n), or new facility assessment/old resident assessment (n/o), the engineer will use the QAP screening survey methods.
2. The engineer will participate in the district strategy/scheduling meeting with the rest of the survey team. The engineer will consider such items as:

- the facility's past record in Life Safety Code compliance,
- types of waivers requested/granted in the past,
- the facility's good faith in complying with the spirit of the law,
- chronic physical plant problems,

before deciding which survey method to use and how many days will be required to complete the survey. If the home's history is questionable or if the engineer is new to the facility, the engineer may decide to use the full SSI or portions of the SSI for the survey.

3. After discussing the home's history, the surveyors will decide:

- Whether the team will do an "old" survey in the home;
- Whether special advisors should accompany the team;
- Which day the advisory NHA should be present;
- Which day the MD should be present;
- When the survey should take place and when the summary (exit) conference should be scheduled;
- When the surveyors should arrive at the home;
- What surveyors should do first at the facility; those areas that should be covered during the tour;
- When the team critique of the survey should take place.

If the team decides to use the "new" survey method and the engineer feels that s/he may require more time in the facility than the "usual" one or two days, the engineer may schedule additional time after the "new" survey for immediate follow-up to the screening process.

The engineer should attend the strategy/scheduling meeting when possible since this allows all surveyors to discuss each facility's problems and to finalize plans for the survey. If the engineer cannot attend the scheduling meetings because of travel restrictions, surveyors should consider alternatives such as the use of conference calls.

4. Once the surveys have been scheduled, the engineer should complete and submit the Request for QAP Survey Packet form to the Facilities Need Analysis secretary (See attachment). The secretary will prepare survey packets (only for facilities eligible for the new facility assessment) by the third Monday of the month preceding the month of survey, as directed by the engineers.

During the Survey

Entrance

1. When the engineer enters the home with the team on day 1, s/he will participate in the introductions and explanations of the QAP survey methods. The engineer may want to ask the administrator:

- What changes have there been in the facility during the past year?

- Have there been problem areas related either to construction and/or operation?

- To have the following documentation assembled during the brief tour:

- *fire drill, disaster drill, fire alarm test logs;

- *generator or emergency power test logs;

- *fire ratings of carpets, draperies, wall coverings (finishes);

- *preventive maintenance program.

2. If the engineer enters on Day 2, s/he will explain the PE survey methods to the administrator and ask the same questions listed above.

Brief Tour

1. The engineer tours the facility with administrator and/or key staff (i.e., DON, maintenance engineer) who has access to all areas. If the engineer enters on Day 1, s/he will accompany the rest of the survey team on tour. When the engineer enters on Day 2, s/he will tour alone with facility staff or possibly with advisory NHA. If the engineer tours without other team members, the activities listed under brief tour and extended tour should be combined.

The following are suggested screening techniques and are not meant to be all inclusive.

During tour:

- Ask questions of administrator (or other staff) as you go along.
- Pick up general impressions of the facility using 5 page Facility Assessment Worksheet as a guideline for what to look for. (Forms attached)
- How does administrator (or other staff) relate to residents and staff during tour?
- Note areas administrator (or other staff) obviously wants to show off or gloss over.
- Jot down quick notes to remind yourself of questions/areas you may want to look into later.
- Spot check exits for lighting and obstructions.
- Spot check a few patient rooms for adequate furniture placement, storage space and equipment.
- Try nurse call system in a few rooms to see if conveniently located and operational.
- Spot check smoke/fire doors at random to see if appropriately located and operational.
- Spot check doors to hazardous areas on patient floors for protection features.
- Note areas where there are odors or stale air.
- Note items which may indicate poor maintenance systems, i.e., dirty grills, peeling paint, loose handrails, leaking faucets, etc.
- Watch for obstructed hallways.
- Check for proper handling of oxygen if you see it in use.

- Note whether physical layout is conducive to quality care, i.e., number and location of nursing stations.
- Spot check hazardous areas to determine if combustibles, poisons or other hazards are stored properly and if the amounts have increased to the point of causing a hazardous situation.
- Check interior accessibility of phone and toilet for the handicapped.
- Check for indication of any alteration (new construction, remodeling, or change in usage) of areas from the year before.
- Spot check the maintenance inside and outside the building.
- Interview a variety of staff members, i.e., nurses aides, LPN's, dietary personnel, housekeeping staff, about fire drill procedures. Questions engineer might ask about drills are:

*how often?

*can they hear the alarm?

*are smoke doors closing properly?

*what do they do during a fire drill?

*how are fire drills carried out?

*what would you do upon discovering a fire in a resident's room?

*what would you do if you discovered a fire in a dryer?

2. During the Facility Assessment, when you identify a problem, try to determine whether it is an isolated incident or an overall breakdown in a system. This decision will determine whether in-depth code application is necessary.

Extended Tour

1. As you proceed with the extended tour, check additional items for those areas listed above where you noted possible problems. Try to verify the problem's existence, magnitude, source and degree of impact on residents through a variety of strategies:

- Observations;
- Interview with staff;
- Review of documentation (policies/procedures);
- Other team members' reactions;
- Agreement between staff interviews and your own observations.

2. Review fire drill, disaster drill, fire alarm test logs, generator or emergency power test logs, fire ratings of carpets, draperies, finishes and preventive maintenance program documentation. Do the written procedures and other documentation agree with your observations/interviews during the brief tour?
3. Continue tour of building with appropriate staff member(s) until all problem areas noted on brief tour have been reviewed. In addition, you will want to review the following items:
 - Review fire alarm, smoke detectors, smoke dampers, sprinkler systems, battery power packs, generator, nurse call systems, communication systems with maintenance person to determine if appropriately located and well maintained;
 - Explore whether preventive maintenance is effective for environmental systems, i.e., heating, ventilation, plumbing, etc.;
 - Review last year's waivers. Have conditions changed or are the waivers still appropriate?
4. Interview the Administrator and maintenance staff
 - Discuss fire drill, disaster drill, fire alarm test logs, and generator or emergency power test logs. Are the policies/procedures adequate, individualized and are the in-services, drills and tests effective in preparing the facility for fire and/or other emergencies?
 - Discuss and review preventive maintenance procedures;
 - Discuss and review maintenance contracts;
 - Discuss and review provisions for emergency water supply.

Executive Conference with Survey Team

1. The engineer will fill out the five page facility assessment (FA) worksheet, marking the areas s/he has observed. The FA worksheet includes 10 sections for subjective evaluation, all related to quality of care. All surveyors are required to complete the entire form during the survey and must mark the N/O (not observed) column if they do not cover that particular item or category. If the engineer is a new surveyor and/or is marking the full Life Safety Code, only page 3 of the facility assessment worksheet must be completed. Discuss and compare your findings with the rest of the team to determine overlap in problem areas. Participate in completing the team Facility Assessment Composite form.

2. The engineer will complete a Summary of Findings form, documenting systems problems, evidence, magnitude, source (if known), and degree of impact on resident. Decide upon appropriate state action, i.e., no action necessary, further investigation, counseling at the exit conference, consultation at a later date, calling in a special advisor, and/or citation of deficiencies. Documentation and follow-up actions should be aimed towards the most effective method of correcting a home's problems.
3. The engineer will mark the full federal Life Safety Code portion of the SSI if:
 - a. S/he has not surveyed the facility previously, or
 - b. There have been additions to the building, or changes in usage of areas which invalidate the past integrity of the Life Safety Code, or
 - c. When deficiencies are discovered which were undetected in the past and which may or may not affect the decision to continue approval of past waivers, or
 - d. When a new waiver is requested.

Changes in the Life Safety Code may be reported by updating the xerox copy provided and issuing NOV's when appropriate. The engineer is expected to complete the LSC while s/he is in the facility.

4. Serious deficiencies which are not contained in the LSC but which directly affect resident well-being should be cited using the standard NOV form. The non-LSC portion of the SSI does not have to be marked when non-LSC deficiencies are cited.
5. The engineer may choose to complete portions of and/or the full SSI if extensive problems are discovered during screening. Such problems may be:
 - a. Maintenance negligence;
 - b. Deterioration in compliance from previous surveys.

Summary Conference with Facility Staff

1. The Facility Assessment Coordinator (RS) presents the Facility Assessment Composite and the Summary of Findings forms to the administrator. The survey team members elaborate on explanations of problems found in their area of expertise, providing counseling when appropriate and/or explaining the state actions.

2. NOV's should be called into the Facilities Need Analysis secretary as usual. NOV paperflow will be handled according to current procedures. The engineer should inform the FAC (RS) where the NOV's will be sent so the survey packets will not be held in the district offices. The engineer gives all other forms (Facility Assessment Worksheet and Summary of Findings) to the FAC for inclusion in the survey packet.

After the Survey

1. The engineer should participate in the survey critique session when the team reviews the survey, the team's performance, and the home's response. If the engineer cannot be present due to travel constraints, some alternative method, such as a conference call, should be arranged.
2. After the POC's are obtained the PE will submit his/her packet to the Facilities Need Analysis secretary who will have a list of all QAP homes. If the home is on the list, QAP will be notified. QAP will pick up the PE packet and review it along with the other disciplines' packets for documentation purposes. The entire packet will then be submitted to the Long-Term Care Section clerk.
3. Facilities Regulation Section will review forms for licensure/certification.
4. Region V will receive the following documentation for T19 facilities:
 - All NOV's;
 - The full LSC portion of the Single Survey Instrument when Facilities Regulation Section would routinely send this to the Region;
 - Waiver justification documentation;
 - Summary of Findings when Facilities Regulation Section routinely sends these forms to the Region.

LJ:to 5567

10/79

TO: BILLY SEIBERLICH

FROM:

RE: Request for QAP Survey Packet

FACILITY: _____ DATE: _____

PACKET
NEEDED: _____

Check forms needed.

- | | |
|--|---|
| ☐ QAP survey forms | ☐ Computer face sheet |
| ☐ Last year's SSI | ☐ Blank SSI |
| ☐ Facility profile (LTCIS) | ☐ Floor plans, if available |
| ☐ LSC sign off sheet | |
| ☐ Xerox copy of last year's Life Safety Code | |
| ☐ Last year's waived violations prepared by OSC | |
| ☐ Last year's NOV's, justification memo and VV log sheet | |
| ☐ Blank NOV's with header information typed, specify number needed | _____ |
| ☐ Other (list) | |

This form must be completed and returned to Billy by the second Monday of the month.

ATTACHMENT 30

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

REGION V

175 W. JACKSON BOULEVARD
CHICAGO, ILLINOIS 60604

HEALTH CARE FINANCING
ADMINISTRATION

December 7, 1979

Ms. Laurie Joiner, Acting Director
Quality Assurance Project
Bureau of Quality Compliance
Department of Health & Social Services
Division of Health
131 West Wilson Street
Room 905
Madison, Wisconsin 53703

Dear Ms. Joiner:

This is to restate the agreements made on November 15, 1979 in Madison regarding the role of the Life Safety Code engineer in the Quality Assurance Project screening survey and the project's requirements for submitting appropriate documentation to the Regional Office for project facilities. The first section of this letter indicates the procedures that were agreed upon at the meeting; the remainder of the letter reiterates the Regional Office's existing documentation requirements under the reporting by exception procedures which were also discussed at the meeting.

As was agreed, the engineer surveyor will complete the full federal Life Safety code portion of the survey instrument when:

1. S/he has not surveyed the facility previously, or
2. There have been additions to the building, or changes in usage of areas which invalidate the past integrity of the Life Safety Code,
3. When deficiencies are discovered which may affect the decision to continue approval of past waivers, or
4. When a new waiver is requested, or
5. When a waiver has been previously denied.

For purposes of the duration of the project waiver, county owned and operated facilities can be included in the screening process with one exception; the procedure does not apply to any county owned or operated facility in which a full life safety code survey must be conducted in accordance with the above established procedures.

The issue was also raised regarding transmittal of the reports of comparative surveys conducted of project facilities by the Program Review Branch of the Division of Survey and Certification Operations. As was agreed, reports of comparative surveys will be forwarded to the Director, Bureau of Quality Compliance; this is identical to procedures established for the transmittal of reports of non-project providers to the State Agency. A copy will also be sent to the HCFA project officer.

The following procedures were previously established with the Bureau of Quality Compliance for all types of providers, including nursing homes not receiving new method surveys under the Quality Assurance Project. In those instances in which the following conditions exist, it will be necessary for all facilities, including project homes, that the full single survey instrument including health and Life Safety Code documents, be completed and forwarded to our office:

1. All initial certifications,
2. Changes of ownership,
3. All facilities where an adverse action is recommended, e.g., termination, non-renewal of a time-limited agreement,
4. All skilled nursing facilities with waiver requests for seven-day R.N. coverage and Medical direction and Life Safety Code (in accordance with approved procedures).

In all cases, established Bureau of Quality Compliance procedures are to be followed when survey packages are forwarded to the HEW Regional Office in so far as completion of appropriate forms is concerned. These forms include the following:

1. Certification and Transmittal (HCFA-1539),
2. Application to Establish Eligibility (HCFA-1516),
3. Notice(s) of Violation,
4. Waiver documentation and recommendation;
5. Nurse Staffing - SNF
6. Staffing - ICF - Nurse and Housekeeping,
7. Crucial Data Elements Forms

We would also like to point out that the procedures outlined in this correspondence are applicable to facilities participating only in the Title XIX program. There has been no change in reporting by exception procedures established for facilities participating in the Title XVIII program or in both the Title XVIII/XIX programs.

We hope this clarifies the issues raised during our meeting and resolves any outstanding issues. Questions or comments concerning this matter can be addressed to Dr. Straub so that any problems can be promptly resolved.

Sincerely yours,

Richard A. Hall, Pharm.D.
Director
Division of Survey & Certification
Operations
Regional Health Standards & Quality
Office

K. Mary Straub, Ed. D
Project Officer
Office of Research Demonstrations and
Statistics

ATTACHMENT 31

Present Documentation Requirements for
Medicaid-Medicare Recertification Used
by the Bureau of Quality Compliance (Non-QAP)

	<u>T 18 SNF</u>	<u>T 19 SNF</u>	<u>ICF</u>
Certification and Transmittal (HCFA 1539)	X	X	X
Request to Establish Eligibility (HCFA 1516)	X	X	X
Crucial Data/Deficiency Report (replaces NOV)	X	X	X
LSC Crucial Data	X	X	X
Staffing Pattern and Census Data (HCFA 1569)	X	X	X (HCFA 3070)
Ownership Disclosure (HCFA 1513)	X	X	X
If LSC waiver involved, Fire Safety Survey Report (HCFA 2786)	X	X	

State of Wisconsin \

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

April 1, 1980

DIVISION OF HEALTH
MAIL ADDRESS: P. O. BOX 309
MADISON, WISCONSIN 53701

IN REPLY PLEASE REFER TO:

Mr. Walter Hedrick
Program Review Branch
Health Care Financing Administration
DHEW, Region V
175 W. Jackson Blvd.
Chicago, Illinois 60604

Dear Mr. Hedrick:

The report of the federal validation survey conducted at [REDACTED] in [REDACTED], Wisconsin, has been reviewed and compared with the state survey report by Bureau of Quality Compliance and Quality Assurance Project staff.

Our recommendations and comments are as follows:

1. Environment and Sanitation 45 CFR 249.12(a)(6) T-152. There is some question whether this is an appropriate citation under this regulation since the bat droppings were discovered in the attic, which is not a patient use area. The attic at this facility is fully sprinklered.
2. Life Safety Code Survey - We are unsure whether ROFEC has compared our survey and the validation survey. We have made our own comparison as follows:

K-8 10-1322 Construction Type
Waived by State.

K-13 10-1331 Corridor Walls
Waived by State.

K-19 10-2321 Stairway Enclosure
Engineer supervisor will discuss and follow-up with state surveyor.

K-21 10-2246 Hazard Area Doors
Cited by State.

K-26 10-2212 Exits
Engineer supervisor will discuss and follow-up with state surveyor.

K-30 10-2233 Corridor Width
Waived by State.

Mr. Walter Hedrick
April 1, 1980
Page two

K-33 10-2242 Door Width
Waived by State.

K-40 10-2272 Exit Lighting
In compliance at time of state survey.

K-46 10-2331 Floor Covering
In compliance at time of state survey.

K-63 10-2351 Hazardous Areas
Engineer supervisor will discuss and follow-up with
state surveyor.

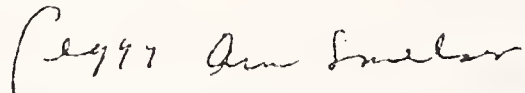
K-66 17-4111 Evacuation Plan
In compliance at time of state survey.

We have not requested plans of correction for the violations you discovered. This is because our regular survey of the facility will be taking place shortly and will result in new violations and POC's which should satisfy your needs and ours. It seems wasteful to generate more paperwork in the interim for both our agencies when none of the violations you found are immediately life threatening.

Thank you for sharing the validation survey reports with us. In the future, we would appreciate receiving the reports of the federal validation surveys closer to the date of the original survey so that we may take appropriate action, if necessary, with the facility in question in a more timely fashion.

If you have additional questions about our response to this validation survey, please contact me at (608) 267-7185.

Sincerely,



Peggy Ann Smelser
Acting Director
Bureau of Quality Compliance

PAS:kk 1064

cc: -Robert Durkin
-Laurie Joiner
-Judy Fryback
-Louis E. Remily
-K. Mary Staub

MASTER LIST OF ALL ROUTINE MONITORING DATA COLLECTED BY THE QUALITY ASSURANCE PROJECT

DISTRICT	TREATMENT CELL	# HOMES BEG. END	DEMONSTRATION PERIOD	METHOD SWITCHES	CORE CRITERIA USE		FREQUENCY OF SURPRISE & OTHER INTERIM SURVEYS	FREQUENCY OF FOLLOW-UP ACTIONS BY TYPE
					EFF. DATE	7/1/81		
#1 Madison	N/N	42	36	4/80-5/82	7/81-6/82	4/80-6/82	4/80-12/81	4/80-2/82
	O/N	43	38	4/80-9/81	7/81-9/81	4/80-9/81	4/80-9/81	4/80-9/81
	N/N	20	20	3/79-2/82	7/81-2/82	4/79-2/82	1/80-12/81	7/79-6/80, 4/81-2/82
#2 Milwaukee	O/O	20	19	3/79-2/82	NA	NA	1/80-12/81	7/79-6/80, 4/81-2/82
	Control	27	27	3/79-2/82	NA	NA	1/80-12/81	7/79-6/80, 4/81-2/82
	#3 Fond du Lac Control	30	15	3/79-3/81	NA	NA	1/80-12/81	7/79-6/80, 4/81-2/82
#4 Green Bay	N/N	50	59	4/80-6/82	7/81-6/82	4/80-6/82	1/80-12/81	4/80-2/82
#5 La Crosse	N/N	9	9	4/78-3/81	NA	1/79-3/81	1/80-3/81	7/78-6/80
	N/O	8	8	4/78-3/81	NA	1/79-3/81	1/80-3/81	7/78-6/80
	O/N	8	8	4/78-3/81	NA	NA	1/80-3/81	7/78-6/80
	O/O	8	7	4/78-3/81	NA	NA	1/80-3/81	7/78-6/80
#6 Eau Claire	N/N	13	13	4/78-3/81	NA	1/79-3/81	1/80-3/81	7/78-6/80
	N/O	17	14	4/78-3/81	NA	1/79-3/81	1/80-3/81	7/78-6/80
	O/N	17	17	4/78-3/81	NA	NA	1/80-3/81	7/78-6/80
	O/O	15	15	4/78-3/81	NA	NA	1/80-3/81	7/78-6/80
#7 WI Rapids	N/N	6	6	4/78-3/81	NA	1/79-3/81	1/80-3/81	7/78-6/80
	N/O	8	7	4/78-3/81	NA	1/79-3/81	1/80-3/81	7/78-6/80
	O/N	6	6	4/78-3/81	NA	NA	1/80-3/81	7/78-6/80
	O/O	8	8	4/78-3/81	NA	NA	1/80-3/81	7/78-6/80

MASTER LIST OF ALL ROUTINE MONITORING DATA COLLECTED BY THE QUALITY ASSURANCE PROJECT (PAGE TWO)

DISTRICT	# VIOLATIONS CITED BY CLASS	SAMPLING OUTCOME	SAMPLING/IOC PERCENT OF INCORRECT CARE LEVELS FOUND	SURVEYOR TIME ALLOCATION - %	POST- MONITORING	
					#NOV	LOC
#1 Madison	4/80-3/82	4/80-3/82	4/80-3/82	4/80-8/80	None	None
	4/80-9/81	4/80-9/81	4/80-9/81	4/80-8/80	10/81-6/82	10/81-6/82
#2 Milwaukee	7/79-6/80, 4/81-2/82	7/79-6/80, 4/81-2/82	7/79-6/80, 4/81-2/82	10/79-6/80	3/82-6/82	3/82-6/82
	7/79-6/80, 4/81-2/82	NA	7/79-6/80, 4/81-2/82	10/79-6/80	3/82-6/82	3/82-6/82
	7/79-6/80, 4/81-2/82	NA	7/79-6/80, 4/81-2/82	10/79-6/80	3/82-6/82	3/82-6/82
#3 Fond du Lac	7/79-6/80	NA	7/79-6/80	10/79-6/80	NA	NA
#4 Green Bay	4/80-3/82	4/80-3/82	4/80-3/82	4/80-8/80	None	None
	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
#5 La Crosse	7/78-6/80	7/78-6/80	7/78-6/80	7/78, 6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	NA	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	NA	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
#6 Eau Claire	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	NA	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
#7 WI Rapids	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	NA	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	7/78-6/80	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82
	7/78-6/80	NA	7/78-6/80	7/78-6/79, 10/79-6/80	4/81-3/82	4/81-3/82

MASTER LIST OF SPECIAL DATA STUDIES CONDUCTED BY THE QUALITY ASSURANCE PROJECT

STUDY	DATA COLLECTED	DISTRICTS	TREATMENT CELLS/NO. IN STUDY	TIME PERIOD
(1) Baseline data collected prior to start-up. Used to establish level-of-care histories for homes.	Frequency of changes in resident level of care.	1 2 3 4 5, 6, 7W	N/N, O/N N/N, O/O, Control Control N/N N/N, N/O, O/N, O/O (All homes)	1977-1978 1976-1978 1977 1977-1979 1975-1977
(2) Variables used to assign homes to treatment cells.	11 variables used to create a balanced treatment cell assignment: enforcement history, MR population, size, ownership, quality rating, license, survey month, #ICF + #SNF patients, Title 18, and construction year.	1 2 4	N/N, O/N N/N, O/O, Control N/N (All homes)	12/79 1/79 12/79
(3) Cost effectiveness study	Study of operational costs of N/N and O/O survey/resources allocation.	5, 6, 7W	N/N, O/O 12 homes	1/79-4/79
(4) Complaint study	Investigated use of frequency of complaints as a quality indicator.	2, 5, 6, 7W	N/N, O/N, N/O, O/O 33 homes	1978-1979
(5) Study of time/quality relationship	Comparison of surveyor time allocation of quality of home using the "pre-test" quality instrument	5, 6, 7W	N/N, N/O, O/N, O/O 72 homes	1978-1979
(6) Surveyor attitude study	Surveyor attitudes toward survey methods and profession.	3, 5, 6, 7W	N/N, N/O, O/N, O/O 18 surveyors	5/79, 3/81
(7) Attitudes toward use of the advisory nursing home administrator (NHA)	Surveyor and NHA attitudes toward use of the NHA.	1, 2, 4, 5, 6, 7W	27 surveyors 29 NHA's	4/80-6/80

STUDY	DATA COLLECTED	DISTRICTS	TREATMENT CELLS/NO. IN STUDY	TIME PERIOD
(8) Repeat problem study	Frequency of repeated violations and problems between annual surveys.	3, 5, 6, 7W	N/N, O/O 45 homes	1978 and 1979
(9) Administrative costs of sampling vs. MA reimbursement costs to nursing homes	Change in reimbursement to nursing homes before and after QAP/old method reviews. Cost of conducting the reviews.	1, 2, 3, 4, 5, 6, 7W	QAP, old 320 homes	1980-1981
(10) Comparison of federal violations by elements, standards and conditions	Number of violations cited which have a federal tag number.	1, 2, 3, 4, 5, 6, 7W	N/N, O/O 60 homes	4/81-3/82
(11) Surveyor time allocation by quality of home	Hours spent on survey and follow-up activities by surveyors	5, 6, 7W 1, 2, 3, 4, 7	N/N, O/O 32 homes N/N, O/O 140 homes	5/80-6/81 5/80-6/81
(12) Comparison of level of care findings under old method on a sample basis in the rural districts (not published)	Changes in level of care and reimbursement to nursing homes under N/N, O/O, and O/O on a sample basis.	1, 2, 3, 4, 5, 6, 7	N/N, O/O, and O/O on a sample basis 72 homes	5-6/82

April 13, 1981

File Ref:

ATTACHMENT 35

Districts #1, #2 and #4
QAP RN and SW Surveyors

Chris Dobbe 
Quality Assurance Project

Resident Review Process in QAP Homes with Out-Of-State Residents.

Some homes eligible for a resident assessment in QAP demonstration districts may have Title XIX residents from another state which contracts with Wisconsin to conduct IOCs on their residents. The states with which we have contracts are Iowa and Illinois. The federal waiver of the requirement to review all Title XIX patients does not apply to these people.

A home in the N/N or O/N cell with out-of-state residents should be reviewed in the following manner:

Illinois or IowaOut-of-State Title XIX
Residents

- delete names from resident census list before applying random numbers
- review residents in addition to the sample using the current Bureau IOC procedure and forms
- complete the Report to Provider as normal
- don't count level changes when making pass/fail determination

All OtherOut-of-State Residents
& Illinois/Iowa non-Title XIX Residents

- keep names on the census list for applying random numbers
- review as normal for resident assessment
- count level changes

Problems of setting level of care should be investigated and documented in both cases.

Please call me at 266-9480 with questions.

CD:to 138190

cc: -K. Bjorklund -L. Remily
-S. Warpinski -J. Kervin
-M. Hillary -D. Cooperrider
-D. Dederich

SUMMARY OF FINDINGS ON FACILITY ASSESSMENT

FACILITY NAME

DATE

ATTACHMENT 36

Team Members' Signatures	Title
	RN
	RN
	SW
	RS
	NHA
Other Advisor(s)	

* Team Coordinator

Facility Staff Names	✓if:	On Duty	Inter- viewed
Administrator			
DON			
Maintenance			
Dietary			
SW			
Activities			
Housekeeping			

	OK OVER- ALL	NOT OK	FINDINGS OF CONCERN
Resident Condition			
Resident/Staff Rela.			
Dietary			
Facility Appear./Envir.			
Recreational Activities			
Resident-Comm. Activities			
Facility Safety			
Care Management			
Special Resident Pop.			
Staff			
Professional Ties			
Management			
Philosophy			
Other			

Other comments, including notation of excellent care or outstanding innovations:

BQC/QAP-5/78:SFA

Department of Health and Social Services, Division of Health, Bureau of Quality Compliance

White - Facility
White - DOH District Office
Pink - QAP Central Office
Canary - Health Care Financing Admin.

P. ___ of ___

Quality Assn. *see Project*
FACILITY ASSESSMENT

FACILITY _____ EVALUATOR _____

DATE _____

N/O*	OK	RESIDENT CONDITION--RN	Time Observed _____	COMMENTS
		-Grooming (shaven, manicured/unkempt)		
		-Odor (no offensive smells/b.o., urine)		
		-Clothing (day clothes/pajamas) (clean/no)		
		-Mood (happy/glum) (open/afraid to talk)		
		-Awareness (alert/drugged/disoriented-no activity)		
		-Use of restraints/positioning (excessive/appropriate)		
		-Physical condition (bed sores/catheters/many geri chairs)		
Problem Areas (Evidence/Source) or Outstanding Innovations				
N/O*	OK	RESIDENT/STAFF RELATIONSHIPS--SW	Time Observed _____	COMMENTS
		-Staff knows residents (who resident was/name only)		
		-Residents rights respected (knock/barge in) (humanize/de-)		
		-Staff attitude toward residents (take time/too busy/alert resident only)		
Problem Areas (Evidence/Source) or Outstanding Innovations				
				Action: ___ No action now ___ Consultation ___ Investigate further ___ Special Advisor ___ Cite deficiency(ies)
				Action: ___ No action now ___ Consultation ___ Investigate further ___ Special Advisor ___ Cite deficiency(ies)

FACILITY

EVALUATOR

DATE

N/O*	OK	DIETARY--RS	Time Observed	COMMENTS
		-Appearance/taste of food (artistic/all together) (appetizing/blah)		
		-Food consistency/temperature (appropriate/inappropriate)		
		-Amount of food (ample/skimpy given number meals a day)		
		-Regular and modified diet menus (nutritionally adequate/ not)		
		-Dining area (clean/dirty) (institutional/social) (rushed/ relaxed)		
		-Assistance in eating (in bed with turn table/in dining room)		
		-Special equipment for self feeding (used/available/no)		
		-Sanitation, maintenance and types of equipment (adequate/ not)		
		-Storage, preparation, handling of food (appropriate/not)		
Problem Areas (Evidence/Source) or Outstanding Innovations				

Action:

☐ No action now

☐ Consultation

☐ Investigate further

☐ Special Advisor

☐ Cite deficiency(ies)

*N/O-Not observed

FACILITY ASSESSMENT

FACILITY

EVALUATOR

DATE

N/O*	OK	FACILITY APPEARANCE/ENVIRONMENT--RS	COMMENTS		Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)
		-Outside maintenance (neat/overgrown) (snow/shoveled walks) (building exterior maintained/not)			
		-Condition of building interior (clean/only in certain areas) (odor/odor-free) (paint peeling/fresh)			
		-Condition of building equipment (fans work/don't) (operable nurse call/no) (elevator maintained/not)			
		-Patient comfort (room temperature comfortable/not) (water too hot/ok) (privacy/none)			
		-New construction/remodeling/redecorating (yes/no)			
Problem Areas (Evidence/Source) or Outstanding Innovations					
N/O*	OK	RECREATIONAL ACTIVITIES--SW	COMMENTS		Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)
		-Between-resident communication (foster interaction/inhibit it)			
		-Variety of activities (many/TV and bingo only)			
		-Residents matched to activities (bedside/activities room/community)			
		-Volunteers (active/little role) (trained/untrained)			
		-Participation (choice/no choice)			
		-Activities held out-of-doors (no/yes, weather permitting)			
Problem Areas (Evidence/Source) or Outstanding Innovations					
					Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)

FACILITY

EVALUATOR

DATE

N/O*	OK	RESIDENT-COMMUNITY ACTIVITIES--SW	COMMENTS
		-Religious (ties to home churches/no services/bedside)	
		-Resident volunteering (active/little role)	
		-Ties to community (gets to town, brings community in/no)	
		-Ties to family (aggressive attempt to involve family/no)	
		-Continuity of lifestyle (can retain some/imposes new lifestyle)	
		-Resident Council (resident-run/ staff run/ no council)	
		-Transportation available (own vehicle/other)	
Problem Areas (Evidence/Source) or Outstanding Innovations			
			Action: — No action now — Consultation — Investigate further — Special Advisor — Cite deficiency(ies)
N/O*	OK	FACILITY SAFETY--RS	COMMENTS
		-Disaster preparedness (staff knows exit patterns/ doesn't) (sprinklers, extinguishers checked/not)	
		-Exits, exit pathways and smoke compartmentation (marked, lighted/ not) (obstructed/not)	
		-Hazards such as combustible liquids and chute doors (properly maintained/not)	
Problem Areas (Evidence/Source) or Outstanding Innovations			
			Action: — No action now — Consultation — Investigate further — Special Advisor — Cite deficiency(ies)

*N/O-Not observed

BQC/QAP-3/78:FA

Department of Health and Social Services, Division of Health, Bureau of Quality Compliance

White - DOH District Office
Pink - QAP Central Office
Canary - Health Care Financing Admin.

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Quality Assurance Project
FACILITY ASSESSMENT

FACILITY

EVALUATOR

DATE

N/O*	OK	CARE MANAGEMENT--RN	COMMENTS
		-Plan of care (everyone involved/only nurses) (goals appropriate/not)	
		-Resident involved in own care (negligible/yes)	
		-Records system (meaningful/routine)(self-helpful/only to met regs)	
		-Resident medical analysis (up-to-date diagnosis, orders/obsolete)	
		-Staff ambulating residents, assisting in eating, stressing fluids, etc. (yes/no)	
		-Staff role in planning, evaluation (periodic reevaluation/none)	
		-Orientation program for resident upon admission (yes/none)	
		-Discharge planning (pat phrases/individualized)	
Problem Areas (Evidence/Source) or Outstanding Innovations			
			Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)

N/O*	OK	SPECIAL RESIDENT POPULATION--SW	COMMENTS
		-Resident room assignment (appropriate/not)	
		-Peer/program contact (available/no)	
		-Handling of problem residents (discharge quick/keep)	
Problem Areas (Evidence/Source) or Outstanding Innovations			
			Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)

*N/O-Not observed

BQC/QAP-3/78:FA

Department of Health and Social Services, Division of Health, Bureau of Quality Compliance

White - DOH District Office
Diab - DAB Central Office

N/O*	OK	STAFF--RS	COMMENTS
		-Number (sufficient/not)	
		-Credentials (appropriate training/poor qualifications)	
		-In-service education (active/not) (academically inquisitive/no)	
		-Mood of staff (self-critical/defensive) (happy/harried)	
		-Attitude toward administration (critical/supportive)	
		-Appearance (neat, clean/sloppy, dirty)	
		-Objectives (interest in improving/just do job) (own goals/no)	
		-Communication (among each other/with resident)	
Problem Areas (Evidence/Source) or Outstanding Innovations			
			Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)

N/O*	OK	PROFESSIONAL TIES--RN	COMMENTS
		-Physician(s) (involved/not) (home tries to involve/doesn't)	
		-Transfer of information from local hospitals (data transfers/doesn't)	
		-Transfer of information to other placements (good/doesn't transfer)	
		-Relation with local physician/clinic for lab/x-ray (yes/no)	
		-Quality and source of ancillary personnel (staff/contract) (involved/not)	
Problem Areas (Evidence/Source) or Outstanding Innovations			
			Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)

FACILITY ASSESSMENT

FACILITY

EVALUATOR

DATE

N/O*	OK	MANAGEMENT--RS	COMMENTS		Action:
		-Administrator and Director of Nurses knowledgeable about residents (know geriatric, MR characteristics/don't)			Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)
		-Staff training and evaluation process (active/not)			
		-Focus of policies (facility/resident benefit/code compliance)			
		-Financial management (sufficient supplies, equipment, staff/no) (appropriate resource allocation/no)			
		-Attitude regarding support professionals, committees, etc. (close monitoring/abdication)			
Problem Areas (Evidence/Source) or Outstanding Innovations					
N/O*	OK	PHILOSOPHY--NHA	COMMENTS		
		-Environment (home/institution)			
		-Resident care (total needs/medical needs only)			
		-Resident influence (have input/don't)			
		-Resident strengths/abilities (fostered/ignored)			
		-Importance of community (still part of life/institution now)			
		-Importance of visiting (discouraged/emphasized)			
		-Objectives (care/dollar only)			
Problem Areas (Evidence/Source) or Outstanding Innovations					
					Action: ☐ No action now ☐ Consultation ☐ Investigate further ☐ Special Advisor ☐ Cite deficiency(ies)

FACILITY NAME

DATE

Team Members' Signatures	Title
	RN
	RN
	SW
	MD
Other Advisor(s)	

*Team Coordinator

Home census today	
# Levels of care too high	# Levels of care too low
# Recommendations for alternate placement made	
# Residents in original sample	
# Residents reviewed by both RN and SW	
# Beyond original sample reviewed (if more, explain below)	

FINDINGS OF CONCERN

	OVER ALL	NOT OK
Nursing--Basic		
Nursing--Restorative		
M.D. Involvement		
Lab and X-Ray		
Medications		
Diet (Basic/Therapeutic)		
Social Services		
Mental Health Serv.		
Physical Therapy		
Occupational Therapy		
Activities/Rec. Therapy		
Speech Therapy/Audiology		
Oral Care		
Vision Care		
Podiatry		
Special Safety Measures/Prostheses/Equipment		
Level of care, Alternate Placement, Other		

Other comments, including notation of excellent care or outstanding innovations:

RESIDENT ASSESSMENT

RESIDENT NAME: LAST, FIRST, MIDDLE				FACILITY NAME AND ADDRESS				ROOM #, BED	
MA or SSI # () PVT. () MC		BIRTHDATE		SEX M F		ADM. DATE ___ From hospital ___ From home ___ From Other		D/C DATE	
								ALTERNATE PLACEMENT RECOMMENDED? Y N	
								CARE LEVEL OK? Y N If not, comment below.	
CURRENT DIAGNOSES:									
ATTENDING MD, NAME and ADDRESS:									
Appearance and condition of resident at this visit:									
Staff description of resident's condition:									
Resident's report of own condition and treatment:									
Staff report of resident's treatment and progress:									
<u>Ambulates</u> <u>Ambulates with assistance</u> <u>Bedridden</u>				<u>Confused</u> <u>Alert</u>		<u>Recent emotional trauma</u> <u>MR/MI primary problem</u>			
Resident Problem or Strength as identified by this reviewer:		Identified by Facility?		Present Treatment or Intervention Provided by or at Facility:		Recommended Treatment or Intervention and Expected Outcome:			
Comments:									

RESIDENT NAME: LAST, FIRST, MIDDLE

FACILITY NAME AND ADDRESS

ROOM #, BED

SCORING KEY: N/A - not applicable for resident N/O - not observed by reviewer

QUALITY OF CARE PROVIDED
- = less than needed
✓ = adequate for this resident's needs

* = optimal for this resident's needs
+ = more than needed

COMPLIANCE WITH REGULATIONS
- = doesn't meet minimum standards
✓ = meets minimum standards

CARE AREAS	N/A	N/O	QUALITY	COMPLIANCE	REASON FOR SCORE--Evidence/Source of Problem
Nursing--Basic					
Nursing--Restorative					
M.D. Involvement					
Lab and X-Ray					
Medications					
Diet (Basic/Therapeutic)					
Social Services					
Mental Health Services					
Physical Therapy					
Occupational Therapy					
Activities/Rec. Therapy					
Speech Therapy/Audiology					
Oral Care					
Vision Care					
Podiatry					
Special Safety/ Prostheses Equipment					
Other					

Reviewer Signature

Date

Physician

Date

RESIDENT ASSESSMENT-LEVEL OF CARE PERFORMANCE EVALUATION

FACILITY NAME

DATE

CHECK ☒ THE NUMBER OF RESIDENTS REVIEWED	WRITE IN THE NUMBER WITH WRONG LEVELS OF CARE	CHECK ☒ THE CORRECT STATEMENT:	
		ACCEPTABLE	IMR/IPR REQUIRED
Out of 10 ☐ residents reviewed,	_____ levels of care were wrong.	Zero? ☐	3 or more? ☐
Out of 11 ☐ residents reviewed,	_____ levels of care were wrong.	Zero? ☐	3 or more? ☐
Out of 12 ☐ residents reviewed,	_____ levels of care were wrong.	Zero? ☐	4 or more? ☐
Out of 13 ☐ residents reviewed,	_____ levels of care were wrong.	Zero? ☐	4 or more? ☐
Out of 14 ☐ residents reviewed,	_____ levels of care were wrong.	Zero? ☐	4 or more? ☐
Out of 15 ☐ residents reviewed,	_____ levels of care were wrong.	1 or less? ☐	4 or more? ☐
Out of 16 ☐ residents reviewed,	_____ levels of care were wrong.	1 or less? ☐	4 or more? ☐
Out of 17 ☐ residents reviewed,	_____ levels of care were wrong.	1 or less? ☐	4 or more? ☐
Out of 18 ☐ residents reviewed,	_____ levels of care were wrong.	1 or less? ☐	4 or more? ☐
Out of 19 ☐ residents reviewed,	_____ levels of care were wrong.	1 or less? ☐	5 or more? ☐
Out of 20 ☐ residents reviewed,	_____ levels of care were wrong.	1 or less? ☐	5 or more? ☐
Out of 21 ☐ residents reviewed,	_____ levels of care were wrong.	2 or less? ☐	5 or more? ☐
Out of 22 ☐ residents reviewed,	_____ levels of care were wrong.	2 or less? ☐	5 or more? ☐
Out of 23 ☐ residents reviewed,	_____ levels of care were wrong.	2 or less? ☐	5 or more? ☐
Out of 24 ☐ residents reviewed,	_____ levels of care were wrong.	2 or less? ☐	5 or more? ☐
Out of 25 ☐ residents reviewed,	_____ levels of care were wrong.	2 or less? ☐	5 or more? ☐
Out of 26 ☐ residents reviewed,	_____ levels of care were wrong.	2 or less? ☐	6 or more? ☐
Out of 27 ☐ residents reviewed,	_____ levels of care were wrong.	3 or less? ☐	6 or more? ☐
Out of 28 ☐ residents reviewed,	_____ levels of care were wrong.	3 or less? ☐	6 or more? ☐
Out of 29 ☐ residents reviewed,	_____ levels of care were wrong.	3 or less? ☐	6 or more? ☐
Out of 30 ☐ residents reviewed,	_____ levels of care were wrong.	3 or less? ☐	6 or more? ☐



Quality Assurance Project

SPECIAL ADVISOR FINDINGS

DIST: White-D.O.
Pink-C.O.
Blue-Adviso

ATTACHMENT 38

FACILITY _____ CITY _____ DATE _____

PROBLEMS FOUND (completed by surveyor)

STAFF INTERVIEWED (completed by special advisor)

☐ Administrator ☐ DON ☐ Maintenance ☐ SW ☐ Dietary ☐ Activities ☐ Housekeeping ☐ Medical Director ☐ Other

FINDINGS OF CONCERN

SOURCE OF PROBLEM(S)

RECOMMENDATIONS FOR CHANGE

Facility _____ City _____ Date _____

Consultant _____

1. Give a brief description of the problem. _____

2. Were you able to attend the in-service/consultation? Yes _____ No _____

3. How much time was spent in the home by the consultant? _____

4. Did you discuss the problem(s) with the consultant before he/she
went in the facility? Yes _____ No _____

For the following questions rate 1,2,3,4 or 5; see key.

5 - yes, totally
 4 - yes, satisfactorily
 3 - yes, with some reservation
 2 - yes, with much reservation
 1 - no, not at all

5. If answer to 4 is yes, was the consultant prepared to
advise regarding that specific problem(s)?

5 4 3 2 1

6. Was the consultant able to develop a working relation-
ship with the nursing home staff that allowed for
positive interaction?

5 4 3 2 1

7. Has the home been receptive to consultation/in-service
in the past?

5 4 3 2 1

8. Was the consultant able to offer alternative sug-
gestions when appropriate to individualize a plan of
resolution to meet the needs of that specific home?

5 4 3 2 1

9. Was the consultant familiar with the appropriate state
and federal regulations?

5 4 3 2 1

10. If not, did this limit the effectiveness of his/her
recommendations?

5 4 3 2 1

11. Was the consultant interested in your perceptions and
your suggestions regarding the facility and its problems?

5 4 3 2 1

12. Would you call upon this consultant again if faced with a
similar problem?

5 4 3 2 1

13. Additional comments: _____

ADMINISTRATOR'S EVALUATION OF
BUREAU OF QUALITY COMPLIANCE SURVEY METHODS

Facility Name _____ Administrator _____

A. Did you know in advance of their arrival that Bureau of Quality Compliance surveyors were coming to your home this week? YES _____ NO _____

B. Please list the three things you liked most about the survey methods:

1. _____

2. _____

3. _____

C. Please list the three things you liked least about the survey methods:

1. _____

2. _____

3. _____

D. Please check the phrases that best characterize the summary or exit conference:

1. _____ Informative _____ Some points not clear _____ Most points not clear

2. _____ Positive atmosphere _____ Atmosphere positive at times and negative at times _____ Negative atmosphere

3. _____ Presented well _____ Some points presented poorly _____ Presented poorly

4. _____ I left knowing what will happen next. _____ I'm unsure of what will happen next in some areas. _____ I do not know what will happen next.

5. _____ I agreed with most points made by the survey team. _____ I agreed with about half of the points made by the survey team. _____ I disagreed with most points made by the survey team.

E. How would you rate the contribution of the following team members to this survey of your facility?

	GOOD	FAIR	POOR		GOOD	FAIR	POOR
Registered Nurses				Sanitarian			
Social Worker				Volunteer Admin. (if any)			
Physician				Special Advisor (if any)			
Engineer (if any)							

F. From your personal observations and the reports of your staff during the survey, how would you characterize the surveyors who made this visit?

1. _____ Very easy to work with _____ Easy to work with most of the time _____ Difficult to work with

2. _____ Knowledgeable and helpful _____ Lacked knowledge in some areas _____ Lacked knowledge in key areas

3. _____ Diplomatic _____ Unyielding in some areas _____ Demanding

4. _____ Fair in their judgements _____ Unfair in some of their judgements _____ Unreasonably strict or lenient in their judgements

RESIDENT ASSESSMENT

RESIDENT NAME: Last, First, Middle

FACILITY NAME AND CITY

ROOM #, BED

Appearance and condition of resident and resident's report of own condition:

Staff description of resident's condition, treatment and progress:

RN/Date

Observation of resident's social needs/condition, Resident's report of own social functioning:

Staff description of resident social and emotional needs:



DIST: White-D.O.
White-FACILITY
Pink-C.O.
Yellow-H.C.F.A.

RESIDENT ASSESSMENT

RESIDENT NAME: Last, First, Middle				FACILITY NAME AND CITY				MENTAL STATUS:	
MA or SSI #	PVT	MC	BIRTHDATE	SEX M F	ADM. DATE From hospital From home From other	D/C Date	ADLS:	ADLATION:	
PERTINENT DIAGNOSES									
Description, Evidence, Source of Problem (Please number.) Note quality and compliance considerations, including inappropriate utilization									
CARE AREAS									
RN									
1 M.D. Involvement									
2 Medications									
3 Diet (Basic/Ther.)									
4 Therapies (specify)									
5 Nursing--Basic									
6 Nursing--Restor.									
7 Lab and X-ray									
8 Other Services									
SW									
9 Activities									
10 Social Services									
11 Discharge Planning									
Surveyor assessment of resident needs and strengths									
Ident. POC Fac? Approp?									
If not optimal, recommended treatment or intervention									
Alternate Placement Recommended? Y N									
Care level in chart									
Care level now									
PPOC required Y N									
PHYSICIAN COMMENTS:									

RESIDENT ASSESSMENT-SW

(ATTACHMENT 42)

RESIDENT NAME: Last, First, Middle

FACILITY NAME AND CITY

ROOM #, BED

	OK	CON- CERNS	N.A.	
RESIDENT INTERVIEW				
1.				Use of time
2.				Participation in own care
3.				Facility respect for resident's rights/privacy
4.				Family/significant other(s) involvement

OBSERVATION				
5.				Mood/posture/body language
6.				Appearance/clothing
7.				Odors
8.				Staff handling of complications/ special needs
9.				Resident's immediate environment (room cheery, own things)
10.				Staff/resident interactions
11.				Activities/use of time

STAFF INTERVIEW				
12.				Resident's use of time
13.				Family/significant other(s) involvement with resident
14.				Resident's participation in own care

DOCUMENTATION				
15.				Scheduled activities/progress notes
16.				Handling of individual needs/ preferences
17.				Handling of complications

*Check appropriate column, use additional space for comments.

SW signature _____

Date _____

RESIDENT ASSESSMENT-RN

RESIDENT NAME: Last, First, Middle				FACILITY NAME AND CITY		ROOM #, B	
*	OK	CON- CERN	N.A.				
RESIDENT INTERVIEW							
1.				Use of time			
2.				Participation in own care			
3.				Satisfaction with care			
OBSERVATION							
4.				Mood/posture/body language			
5.				Grooming/cleanliness			
6.				Positioning/alignment			
7.				Odors			
8.				Physical condition			
9.				Inappropriate use of medication/ side effects			
10.				Staff handling of nursing complications			
11.				Staff/resident interactions			
12.				Resident's immediate environment (safe)			
STAFF INTERVIEW							
13.				Resident's use of time			
14.				Resident's participation in own care			
DOCUMENTATION							
15.				Medications appropriate for problem			
16.				Medications not duplicative			
17.				Abnormal lab and x-ray follow-up done			
18.				Handling of nursing/medical complications/special needs			

*Check appropriate column, use additional space for comments.

RN Signature _____

Date _____



Quality Assurance Project

RESIDENT ASSESSMENT/TEAM

DIST: White - C.O.
White - Facility
Pink - D.O.

RESIDENT NAME: Last, First, Middle

FACILITY NAME AND CITY

MA or SSI#

PVT

MC

BIRTHDATE

SEX

ADM. DATE

RM# or D/C DATE

M F

PERTINENT DIAGNOSES

Team assessment of resident needs and strengths

Ident.
Fac?

POC
Approp?

If not optimal, recommended treatment or intervention

Administrative Order 1.67 Referral? (Circle One) Category 1 2 3 4 N/A

Current Care Level

Final Care Level

PPOC Required Yes No N/A

Team Signatures _____

Date _____



District	Facility	Method1	Dates			Coordinator	
			Facility	Resident	Exit	Facility	Resident

1. Facility assessment/resident assessment
2. Surveyors opted to do old methods based on history of home.
3. Surveyors scheduled surprise survey.



ATTACHMENT 44

Quality Assurance Project FINITE SCHEDULING DOCUMENT

SURPRISE
SURVEY ☐

8

① District _____ Month/Year _____

Facility _____ License # _____ City _____

② Treatment Cell _____ ③ LOC History _____ ④ Survey Method _____

⑤ FACILITY ASSESSMENT

RESIDENT ASSESSMENT

Start Date	Exit Date	ID #
F A Coord.		
Other Team Members		
Special Advisor/s		
Observer		
NHA	Date Needed	
	Priority (circle) H M L	
Name		
Phone		
Facility		

Start Date	Exit Date	ID #
R A Coord.		
Other Team Members		
Special Advisor/s		
Observer		
MD	Name	
	Date	

Areas of Expertise Needed? () financial management () personnel management () nursing services
() therapies () physical plan/environment () community involvement
() dietary () activities/social services () use of support professionals
Other _____

⑨ Comments: _____

CORRESPONDENCE/MEMORANDUM

STATE OF WISCONSIN

Date: February 26, 1981

File Ref:

ATTACHMENT 45

To: Districts 5, 6, 7W Surveyors

From: Ken Bjorklund, Chief, Long Term Care Section *KB*
Steve Schlough, Chief, Facilities Need Analysis Section *SDS*

Subject: District Survey Scheduling Process

As you know, at the March scheduling meetings all April survey nursing homes in Districts 5, 6, and 7W will be scheduled for full resident and facility reviews. QAP method surveys will not be reinstituted in these districts until April of 1982.

We feel this is a good time to look at some of the QAP survey components, assessing their effectiveness for possible statewide implementation. Because Districts 5, 6, and 7W have been using these components in QAP surveys for three years and are now reverting to full surveys, these districts are preferred for piloting survey changes.

The first phase of implementing these components will include survey scheduling modifications. The overall goal of these changes is to achieve tighter team scheduling while reducing scheduling meeting hassles and freeing up surveyor time for more intensive planning for the upcoming surveys.

1. Tentative survey dates will be blocked out before scheduling meeting.

Two days before scheduling meetings, all LTC/FNAS surveyors of facilities in districts 5, 6, and 7W should deliver or telephone their prospective calendar dates for the month to be scheduled to Charles Kirk in District 6. The calendar should show all days the surveyor is available, identifying days scheduled for hearings, vacations, or inservices.

When Charlie receives all the calendars, he will coordinate schedules and block out survey dates that fit everyone's schedule. If there's a conflict, he will notify the appropriate supervisor.

At the scheduling meeting, the proposed schedule can be discussed and fine tuned.

2. Survey teams will meet to discuss survey strategy for that month's surveys.

After finalizing the schedule, teams should discuss their assigned home's history and develop a survey plan. Surveyors should also review the district file (and material sent from central office) before the scheduling meeting. Then, discuss a plan for conducting the survey-- the length of time each surveyor may need, areas to focus on, and whether a special advisor is needed.

District Survey Scheduling Process

February 26, 1981

Page two

Please note that while homes will still be scheduled a month in advance, the strategy sessions will focus on homes scheduled for that month (i.e. March homes will be discussed at the March meeting).

3. More information will be sent to surveyors from central office for homes to be scheduled.

We will try, effective with the April scheduling meeting, to send the SSI and a copy of all nursing home/central office correspondence the district wasn't previously sent. This material is to be returned to central office by the following month's scheduling meeting.

A copy of the March calendar is attached for you to use for this round of scheduling.

Your feedback regarding these points will be solicited at the March scheduling meetings which we now plan to attend. We will be discussing other survey modifications with you at that time; the team coordinator concept and the systems approach to survey. Meanwhile, call your supervisors with questions about the scheduling changes outlined in this memo.

KB/SS/jm

cc: G. Anderson
D. Cooperrider
M. Hillary
J. Kervin
C. Kirk
K. Lamm
L. Remily
M. Stearns
S. Warpinski

Attachment (1)

bcc: C. Dobbe
J. Fryback
P. Swalser

Quality Assurance Project
Role of the Advisory Nursing Home Administrator
In the Demonstration Survey Methods

Quality Assurance Project administrative staff will initially contact and schedule you for the date the survey team has requested. It may be the first or second day of the facility assessment.

The Division of Health surveyor who is coordinating the facility assessment will call you prior to your survey date and give you the specifics on where you will meet the team.

Once with the team, you will be briefed, again by the coordinator, as to what the home's history has been and what problems or strengths have been observed. If it is the first day of the survey you will tour the facility with the team. Otherwise, at this time, you may wish to meet the administrator and tour the facility.

It is your task to assess:

- whether the home has identified the problem
- if they are willing to change
- if they can correct the problem themselves

Some good indicators that the home is moving to correct a problem are:

- have specific (detailed) goals for change been identified?
- have they requested involvement of external expertise?
- do they understand the cause of the problem?
- is there a plan, step-by-step, for phasing in the change?

You may gather information to make these judgments through interviews with facility staff, through reviews of policies and procedures, or via discussions with surveyors. Due to the confidentiality of resident charts, you will not be reviewing documentation contained therein, however.

You will complete the five-page facility assessment tool. Special focus should be placed on marking the last criteria on the form-- Management and Philosophy/General Impressions.

You will meet with the facility assessment coordinator to discuss your findings. At this time you will summarize problems noted with an analysis of what it will take to cause the nursing home to change on the Special Advisor Findings form.

If you have been scheduled for the first day of the facility assessment, you will attend a conference with one or more surveyors and the facility administrator to discuss findings and recommendations. When you are scheduled for the second day, you will attend an hour summary conference with the surveyors, facility administrator, and any facility staff present to discuss the team's (and your) findings and recommendations.

You will turn in all survey papers to the team coordinator, but return the travel voucher information to the project staff in Madison.

TELEPHONE INTERVIEW

NHA RESPONSE TO PARTICIPATING IN A NEW METHOD SURVEY

Name: _____

Nursing Home Affiliation: _____

Home Surveyed: _____

District: _____

Date of Survey: _____

Day of Participation: _____ No. of Hours on Survey: _____

1. Did the training you received from the Quality Assurance Project enable you to adequately perform your role? _____ Yes _____ No

If not, how could it have been improved?

2. Did your contact with the QAP staff regarding this survey give you:

- a) an accurate estimate of driving distance? _____ Yes _____ No
- b) enough information about how the Division of Health Surveyors would contact you? _____ Yes _____ No
- c) sufficient explanation of the reimbursement process _____ yes _____ no

3. Did your contact with the Division of Health surveyors regarding this survey give you:

- a) adequate notice? _____ Yes _____ No
- b) satisfactory directions to the facility? _____ Yes _____ No
- c) enough background information on the facility? _____ Yes _____ No

4. On which day of the survey would you prefer to participate?

_____ day 1
_____ day 2

5. Was there enough time for you to assess the nursing home? ____ yes ____ no
If not, how much would you recommend?

6. What specific activities did you engage in during the survey?

7. What skills or knowledge do you feel you were able to contribute to the survey of this home?

8. Did you gain anything for yourself or your facility from your participation on the survey team?

9. How would you generally assess the role of the volunteer NHA on the survey team?

SURVEYOR QUESTIONNAIRE ON USE OF THE NURSING HOME ADMINISTRATOR

TELEPHONE INTERVIEW

Date: _____

Name of FA Coordinator: _____

NHA Participant: _____

Nursing Home Surveyed: _____

District: _____

Date of Survey: _____

1. What was the main contribution of the NHA to your survey of this nursing home?
2. Did you have any problems with this NHA?
3. Did the NHA communicate well with nursing home staff? with members of the survey team?

4. Would you want this NHA to join you on another survey?
5. Do you believe the Quality Assurance Project adequately trained this NHA?
6. Would you recommend this NHA be included on the survey of any particular type of facility or for resolution of any particular problems?
7. On which day of the survey would you prefer to have the NHA participate:
Day 1 _____
Day 2 _____
Consultation _____
8. In general, what do you believe is the major function of including an NHA on the survey team?

ATTACHMENT 48

Report Logging Procedures Employed for
New and Old Method Surveys During Project Years
One Through Three (1978-1981)

<u>Procedure</u>	<u>Purpose</u>
1. <u>Old Method Annual Survey</u>	
Facility Assessment	
-Check nurse, social worker and sanitarian sections of the full survey instrument (SSI) for re- commendations made by surveyors; record in the log book	-for comparison with informal counseling a similar activity under the new method
Record total census of home from census page in the nurse portion of the SSI.	-required information for Quarterly Showing to Region V.
Resident Assessment	
-Report to provider is the document for reporting level of care changes in homes using "old method" resident assessments and for new method homes that opted to have the full inspec- tion of care or flunked the sample. Specific changes in level of care frequency of raised and lowered level of care, number of reviews and date are recorded on spread sheets by district. Also deaths, discharges, hospitalization are noted.	-used to monitor the number of level of care changes in the 10% sample with the number in those homes in which the inspection of care was used.
-From Physicians Observations and Comment sheets, record physician, number of evaluations and hours to perform review in log.	-Used to check level of care performance against the past history of home and against the performance of other homes.
-Monitors time spent by physician for evaluation purposes	
2. <u>New Method Annual Survey</u>	
-Items which are sent on to Long- Term Care Clerk, Rm 421, State Office Building.	

-Screening Assessment Face Sheet; all Summary of Findings pages.

-census page

-if SNF, 2 nurse staffing reports; if ICF, 1 nurse (RN) staffing and 1 sanitarian (RS) staffing report; RN-CDE, RS-CDE forms

-all notices of violation

-interim survey report form for any notice of violation

-yellow buckslip with disciplines issuing notices of violation

-send yellow copy of Summary of Findings pages if one of three conditions exists;

-makes available a copy of the Summary of Findings pages in situations where there is likely to be a request from the region

a. A condition or complete standard is marked out on SSI when the survey team switches to do the full survey or goes back to do the full review as a result of the findings in the screening.

b. If the home requests a seven-day nurse or medical director waiver.

c. If the Region has requested a full survey report on a county facility.

-Send nurse license verification list to Division of Nurses, 1400 East Washington (ID) with a note to return. File a xerox copy in the facility's miscellaneous.

-in accordance with standard procedure normally performed by central office for non QAP homes.

-Record total census, sample size, Medicaid census, and number of Medicaid recipients in log.

-information compiled quarterly and sent to Bureau of Quality Compliance as Utilization Review Report.

-Record all pending actions on tickler system card file.

-Continuous record of follow through on actions initiated at time of survey.

-File pink copy of nursing home administrator evaluation of new methods and hold for quarterly summary. White copy returned to district office secretary once survey is complete.

-File Resident Assessment worksheet in locked resident assessment file.

-File Facility Assessment worksheets in facility assessment file.

3. Notices of Violation (NOV)

- Check NOV's for completeness
 - all state violations classed
 - one H 32 code provision per NOV.
 - header information complete (name, address, etc.)
 - facility's plan of correction has completion date
 - plan of correction appropriate to NOV.
 - verification visit completed by surveyor
 - if there is a waiver, uncorrected violation, or acceptable progress new V.V. date set for verification visit
 - surveyor recommendation

4. Consultations

-Consultation referral to non-surveyors (Bureau of Community Health; Facilities Assistance Section in the Bureau of Quality Compliance; Bureau of Health Care Financing)

- record referral in logs
- xerox copy for files and forward original to central office

-insure that consultations are executed in a timely fashion

-Consultations completed by surveyor

- Record referrals and completion in logs
- return yellow copy to discipline supervisor

- provide a record of changes in the pattern of consulting
- means of monitoring surveyor allocation of time under new method

- Mail letter of evaluation to nursing home administrator, blue form

- enclose form letter 704 for state requested consultation form letter 705 for facility requested

- monitors satisfaction with consultations performed

- Evaluation of consultation by administrator and surveyor
 - record in logs and file

- Record all actions, pending and completed on the tickler card file.

5. Enforcement reports

- Copy and file in facility's miscellaneous file

- surveillance reports
 - complaint reports
 - reports to medicaid fraud unit

ACTION TRACKING CARD

FACILITY _____ LICENSE # _____

CITY _____ SVY DATE _____ SVY REF Y N

PROBLEM _____

ACTION: C/IS SA RV IF O	DATE	
		BY:
		BY:
		BY:
		BY:
		BY:
		BY:
		BY:
		BY:

PENDING ACTIONS FOR:

Green Bay	☐
Madison	☐
Milwaukee	☐

NURSING HOME _____ METHOD _____

SURVEYOR _____ DATE OF SURVEY _____

PROBLEM/ACTION	QAP COMMENTS	DISTRICT COMMENTS
	completed by:	completed by:
	date:	date:

Please return this form to:
Att: Ronnie

QUALITY ASSURANCE PROJECT by or
P.O. Box 309 before _____
Madison WI or phone (608) 266-6646



FACILITY		DATE OF SURVEY

SURVEY TYPE _____

PROBLEM

[illegible]



LONG TERM CARE
SURVEY LOG RECEIPT

TO: _____ DATE: _____ REGION: _____

FROM: LONG TERM CARE FACILITIES SURVEY SECTION

RECEIVED: H 32 _____ SNF _____ ICF _____

FACILITY: _____

COMMENTS:

LTC 1/79



TIME SPAN OF CHRONOLOGY 10/77 - 8/81

TREATMENT CELL N/O

ANNUAL SURVEY METHOD 10/78 N/O
10/79 N/O
8/80 N/O

FOLLOW-UP VISITS

Inservice/Consultation 8
Return to verify recommendations 11
Surprise Survey 1
Verification of deficiencies 6
Complaint investigation 1
Surveillance 4

FACILITY D

Ownership - County
Licensure - Skilled
Certified - T19 SNF/ICF
of Beds - 120
Census - 118
Treatment
Cell - N/O

10-26-77
Annual Survey
17 (C)
13 (F)

The full SSI survey was completed by all four disciplines. As a result, 30 deficiencies were cited. Problems were found in medical direction, pharmacy, nursing services, medical records, governing body and management, restraint orders, dietary, housekeeping, utilization review, facility environment and safety.

5-78
Verification
Visit

All deficiencies were verified corrected.

7-7-78
Complaint
Investigation
RN
4 (B)
1 (C)

Facility social worker filed a complaint with DOH charging that quality of care is poor, residents' right to dignity and privacy disregarded, psychiatrists orders altered or disregarded and social workers office space is inadequate. As a result, 5 deficiencies were issued. Areas included: charge nurse not responsible for total care planning, personal dignity of residents not respected, medication orders and storage space.

8-2-78
Verification
Visit

Three deficiencies corrected, 2 found to be at acceptable progress.

10-2, 3-78
Annual Survey
PE
2 (C)
9 (F)

Annual Screening Survey (QAP) was completed by all four disciplines. Problems were identified in the areas of:

Resident Condition/Resident and Staff Relations

- Resident clothing uncoordinated, washed out
- Little interaction between staff and residents
- Activities observed did not seem proportionate to activities documented
- Restorative nursing is not being carried out appropriately
- Rehab. services not being fully utilized

Facility Appearance and Environment

- Storage area limited
- Hallways cluttered
- Building needs repainting
- Areas of plaster falling off
- Exterior generally untidy

Management

- Policies and procedures to effectively utilize and support professional services are not current or complete
- Roles and responsibilities of disciplines not clear
- RN's not permanently assigned to a unit
- Hiring at facility done within the system regardless of qualifications

State action included consultation regarding rehabilitation services, restorative care, activity programming and care planning; 11 NOV's were issued by the engineer and several recommendations were made to the facility requiring a return visit by state surveyors. Nursing home board members were present at the exit conference and were made aware of the problems at the facility.

12-5-78
Telephone
Verification

Unable to do onsite verification due to weather. Surveyors verified that some progress was being made in the areas of management and restorative care.

1-30-79
Follow-up
Visit

RN and RS return for follow-up. Surveyors determine that recommendations are not being acted upon by the facility in a timely manner. Surveyors decided to return to issue NOV's.

2-14-79
Consultation

RN surveyor provided inservice on resident care planning.

2-22-79
Consultation

RN surveyor provided inservice on bowel and bladder program.

2-26-79
Interim Survey
RN 2 (B) 3 (C) 2 (F)
SW 1 (C)
RS 1 (B) 7 (C)

A total of 16 NOV's were issued by the RN, SW and RS. Areas cited included:

- no written reports by social services consultant
- irregularities of medications
- supervising RN's not responsible for total care
- activity program is not planned to meet needs of residents
- patient care plans lack current specific measurable goals
- medications given prior to MD orders written
- patient care plans and nursing notes lack documentation of restorative nursing
- exits not shoveled
- food stored in activity area
- eating utensils not stored in clean areas
- southeast entryway carpet worn
- pop and other case goods stored on floor in activity area
- southeast stairwell used to store empty boxes
- garbage bags thrown at snowbound trailer
- residents not treated with consideration, respect and recognition of dignity

2-28-79 Consultation	Consultation provided by RN on restorative nursing. Consultation provided by State O.T. on activity programming.
5-2-79 Verification Visit	Status of NOV's issued on 2-26-79. RN 4 corrected, 2 acceptable progress, 1 not corrected. RS all corrected. SW all corrected.
5-10-79 Consultation	Consultation provided by RN on Care Planning.
5-17-79 Consultation	Social worker provided consultation to new SW regarding the role of the SW in the nursing home.
5-21-79 Consultation	Consultation provided by RN on implementation of care plans.
5-28-79 Surveillance	Monthly surveillance begun in the areas of patient care, restorative care, activity programs and facility environment.
6-5-79 Surveillance	Surveillance report indicates overall conditions appear to be satisfactory. Maintenance personnel have been hired and facility appearance has improved. Conditions on the nursing units have also improved. All NOV's either corrected or at acceptable progress.
8-10-79 Surveillance	Resident care areas appeared neat and clean. DON making continued progress in organization of Nursing Services. Charge nurses aware of individual residents needs and the progress made by residents in therapy. RN recommends that facility be taken off surveillance.
8-17-79 Surveillance	Facility taken off surveillance.
10-3, 4-79 Annual Survey	Annual screening survey completed by all four disciplines. In general, steady improvement was evident in all previous problem areas.
PE 8 (F)	-residents look much better -interaction increased -facility appearance much better -nurses notes descriptive and complete -care plans coming along well -variety of activities offered, residents getting out into the community -social worker doing a good job -floor nurses supervising nurse aides -NHA and DON are functioning as supervisors

-supervisory and communication lines have been established

Problems were found concerning restraint orders, medication storage, quarterly accounting of resident funds, discharge planning, small maintenance items, amount of activity staff time, under utilization of psychiatric and PT services and various management issues. PE issued 8 federal violations, all of which are waivable items.

There was still a need for continued monitoring since several of these problems had been chronic. Surveyors attributed the majority of improvements to the changes in the style and function of management and supervision. Most of the changes occurred as a result of informal consultation by surveyors to key facility staff. Surveyors feel that the plans for the new facility have greatly improved resident and staff morale.

10-30-79
Follow-up
Visit

RN reviewed medical histories, medication storage and restraint orders. All areas found satisfactory. Activity Director will be resigning in November. Surveyors will refer State Activities Consultant to aid in orienting Activity Director when hired.

11-20-79
Follow-up
Visit

Facility appearances continued to improve. Facility housekeeping staff monitoring conditions daily.

12-14-79
Telephone
Follow-up

Facility hired activity director. State will provide consultation early in 1980.

2-5, 6-80
Federal
Validation
Survey

Federal findings concluded that "The Triage survey seems adequate in monitoring the performance of this facility." All conditions of participation were met; 1 standard and 18 elements were out of compliance. (See attachment for additional information.)

2-21-80
Consultation

Verification
Visit

Consultation provided by RN and SW surveyor and State O.T. Consultant. NHA, Activity Director and SW were present. Problems previously found in the areas of resident accounts and discharge planning have been resolved. Facility also successfully enrolled 10 residents in a sheltered workshop program.

8-7, 8-80
Annual Survey

PE
2 (C) 4 (F)

Annual screening survey completed by all four disciplines. Problems found in the areas of unlocked poisons, contracts for therapy services, facility inservices for PT and disaster preparedness, facility environment and safety. Counseling was provided during the exit conference and surveyors will return to verify correction within 2 months. Six NOV's were issued by the engineer, all were waiverable items.

Overall surveyors noted continued improvement in all past problem areas. Key staff are functioning as supervisors with the result being a well maintained facility. Activity programming is geared to individual resident needs with a good variety. MD coverage is excellent. Facility appearance is in much better shape. New facility is under construction and will be completed by mid 1981.

10-27-80
Verification
Visit

The facility is no longer using a poisonous compound to sanitize utensils, preventative maintenance is being carried out on a continuous basis and contracts for therapy services have been arranged. The facility has held inservices for all employees in the areas of fire safety, disaster preparedness and physical therapy services.

8-81
Annual
Survey

PE
10 (F)

The annual survey was completed by all disciplines. All state and federal codes were applied. The engineer cited eight waiverable items and two federal violations. No other deficiencies were cited.

Recommendations were made by the social worker regarding resident involvement in care planning, increased follow-up on ADL training, including social service intervention in quarterly assessments, expanding the 1 to 1 and small group activity programs, including the activity plan on the PPOC, more comprehensive activity progress notes and revising the policies and procedures of the activity department.

Recommendations were made by the nurse concerning medical records, clarification of policies and procedure and additional topics for inservice. Regarding pharmacy issues, the nurse recommended that the facility provide an area for the pharmacist to communicate concerns to the attending physician, clarify reorder method for schedule II drugs, consider obtaining approval on a standing basis for disposal of controlled substances, clarify orders and usage of PRN meds, including expiration date on the outside of the emergency kit and clarify policy for bedside emergency meds.

The sanitarian had the following recommendations. Consider using smaller rooms off the main dining room for special groups, i.e., feeders. Complete a tray time study. Expand existing procedures for supervisory personnel.

8-81

Replacement facility.

REPORT OF SURVEY OBSERVATION

Name of Home _____ City _____

Survey Dates _____ Observation Dates _____

Miles from District Office _____

FACILITY TEAMRESIDENT TEAM

_____ *

_____ *

_____ NHA

_____ MD

List Appropriate Times:

	First Day	Last Day	Addt'l Day
Enter Facility	_____	_____	_____
Leave Facility	_____	_____	_____
# RA's Completed	_____	_____	_____
Total Lunch Time	_____	_____	_____
Total Travel Time	_____	_____	_____
Start Tour/Total Tour Time	<u> / </u>		
Total Time of Executive Session		_____	
Total Time of Exit Conference		_____	

RESIDENT SAMPLE TOTAL # OF RESIDENTS	HOME CENSUS	# IN SAMPLE	% OF SAMPLE
T.19			
T.18			
Pv. Pay			
SNF			
ICF			
Geriatric			
DD			
Unit I			
Unit II			
Unit III			

Entrance/Tour

1. Briefly summarize the introductions?
2. What areas were observed on the tour?
3. What problems were identified on the tour?

Resident Assessment

4. Was the sample checked for representativeness? Y N
5. Were additional residents added to the sample? Y N If yes, why?
6. Estimate the time spent for each activity per resident.
- Resident Interview _____ Resident interviews as a team? Y N
- Staff Interview _____ Staff interviews as a team? Y N
- Chart Review _____ Team Assessment _____
7. Briefly summarize the RA process?

Facility Assessment

8. List an area reviewed by each discipline, estimate total time of review.

	Area Reviewed	Discipline	Total Time
a.	_____	_____	_____
b.	_____	_____	_____
c.	_____	_____	_____
d.	_____	_____	_____
e.	_____	_____	_____

For each area reviewed, list observations made, people interviewed and paper reviewed.

a.

b.

c.

d.

e.

9. Briefly summarize the role of any special advisors.

Executive Session

10. What problems were identified by more than one discipline?
11. What input did the NHA and/or MD and/or consultant have during the executive session?
12. What format/strategy was determined for the exit conference?
13. Briefly summarize the executive session?

Exit Conference

14. Did surveyors explain the impact of problems on resident care?
15. Did surveyors tie problems together (when appropriate) to present a total picture of the home?

16. Briefly summarize the exit conference.

17. Additional comments:

Report completed by _____

Date

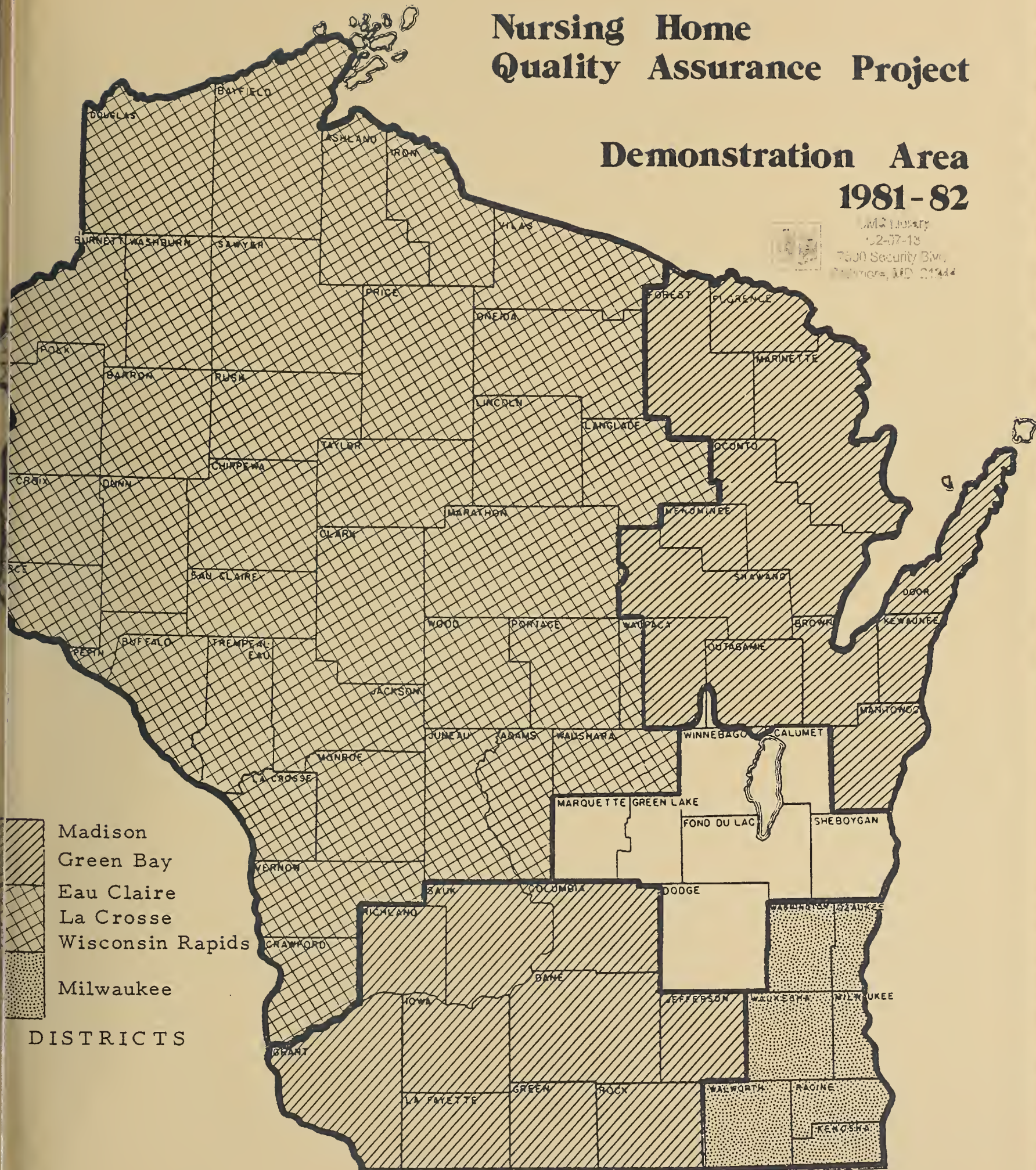
REPORT OF OBSERVATION OF QAP SURVEY METHODS

NAME: _____
AFFILIATION: _____
HOME SURVEYED: _____
DATE (S) OF OBSERVATION: _____

1. Did the orientation you received from the Quality Assurance Project adequately prepare you for the observation? _____ Yes _____ No
If not, how could it be improved?
2. What specific activities did you observe during the survey?
3. How would you assess the role of the volunteer nursing home administrator on the survey team?
4. How does the QAP survey process compare to the traditional survey?
5. Does this survey observation enable you to perform your ongoing tasks better?
6. Would you benefit from additional survey observation?
7. Do you have any additional comments or questions?



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